Patient Safety and the JCAHO Accreditation Standards (Sep 03)

Improving Patient Safety means . . .

Reducing medical errors.

Reducing patient harm.

Objectives

- Discuss the Joint Commission (JC) patient safety standards as they crosswalk to the new 2004 JCAHO Accreditation standards. (Handouts only)
- List the 2004 National Patient Safety Goals (NPSG) with specific recommendations for each goal.
- Describe key changes to the Joint Commission accreditation process (Shared Vision – New Pathway) for 2004.
- Discuss Root Cause Analysis and Sentinel Event trends.
- Discuss the JCs national “Speak-Up Campaign

Useful Handouts

- Test Your Knowledge of Key Acronyms and Abbreviations Related to the Joint Commission
- Test Your Knowledge of Key Acronyms and Abbreviations Related to the HFMEA and RCA Process
- National Patient Safety Goals (NPSG) Quick Reference
- JCAHO Speak-Up Campaign

Role of Accreditation in Patient Safety

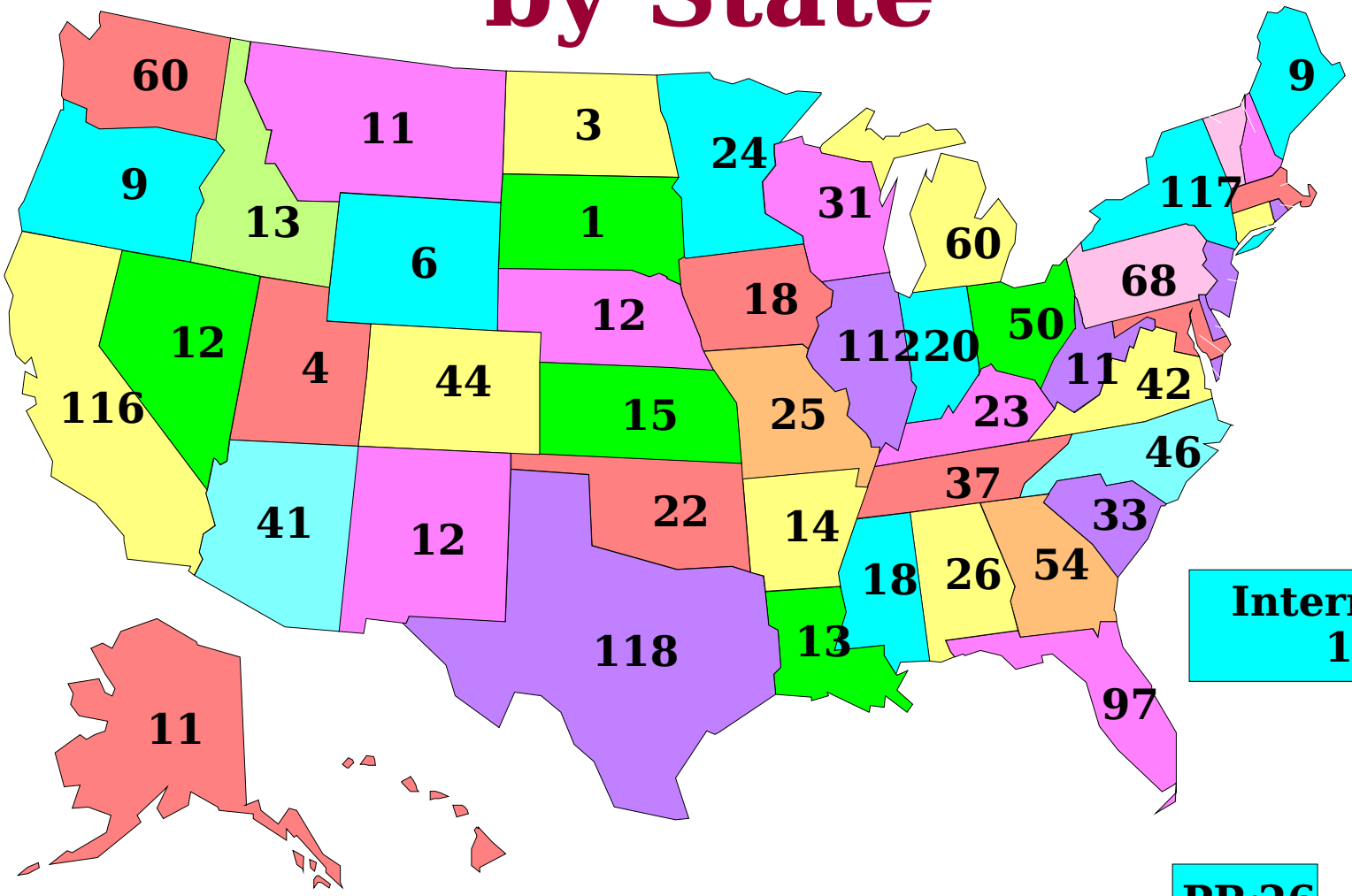
- "Accreditation is, at its core, a risk reduction activity."
  - Setting standards
  - Implementing the Sentinel Event Policy:
    - reporting, analyzing, learning
  - Sharing "lessons learned"
  - Informing the public
  - Influencing national policy
  - Other roles:
    - Convener
    - Collaborator
    - Investigator
    - Educator
    - Publisher

Experience to Date

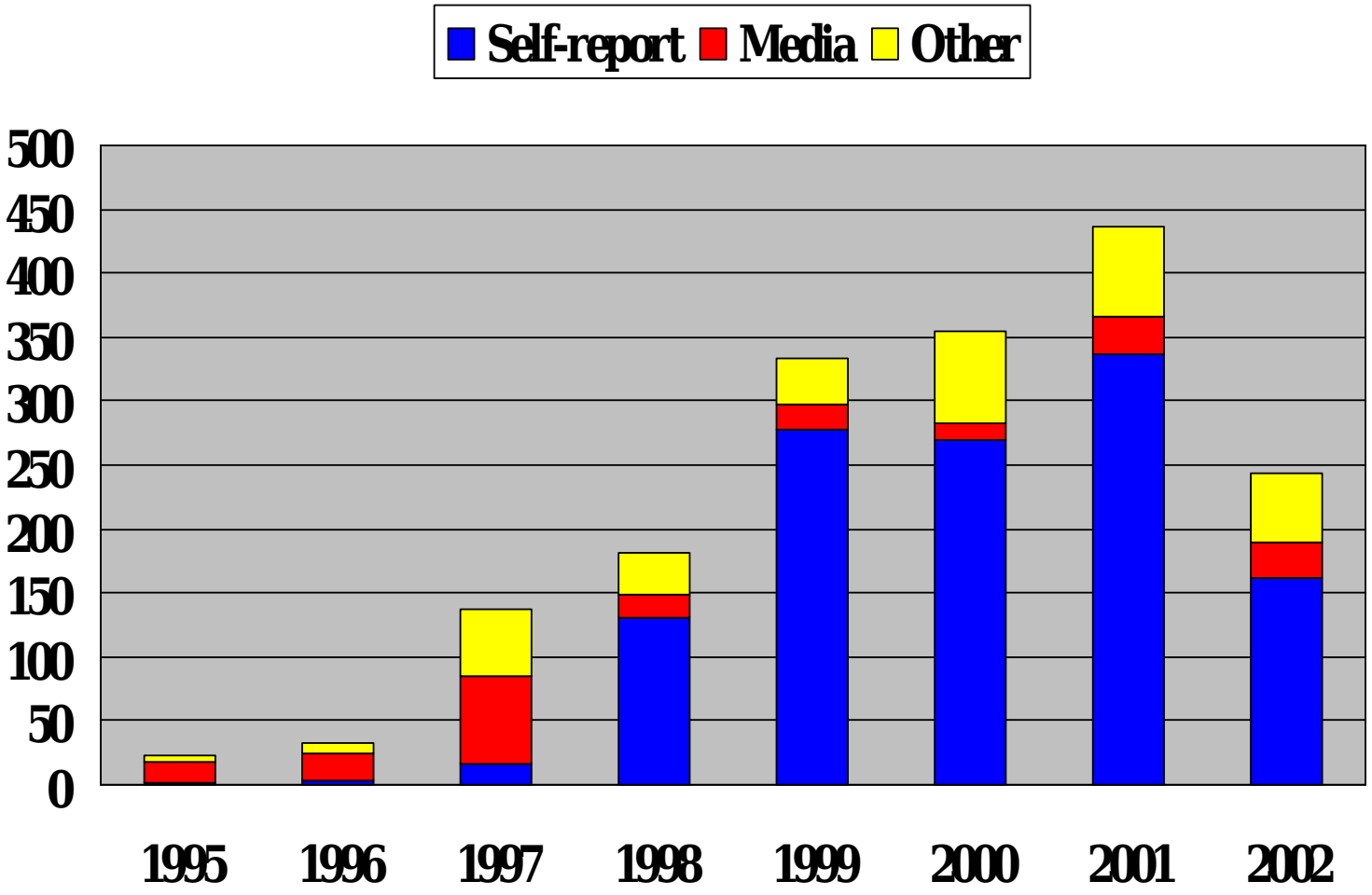
Of 2085 sentinel events reviewed by the Accreditation Committee through June 2003:

336 inpatient suicides
266 operative/post op complications
237 events relating to medication errors
248 events of surgery at the wrong site
125 deaths related to delay in treatment
98 patient falls
101 deaths of patients in restraints
79 assault/rape/homicide
56 transfusion-related events
50 perinatal death/injury
43 deaths following elopement
37 fires
252 “other” less frequent types

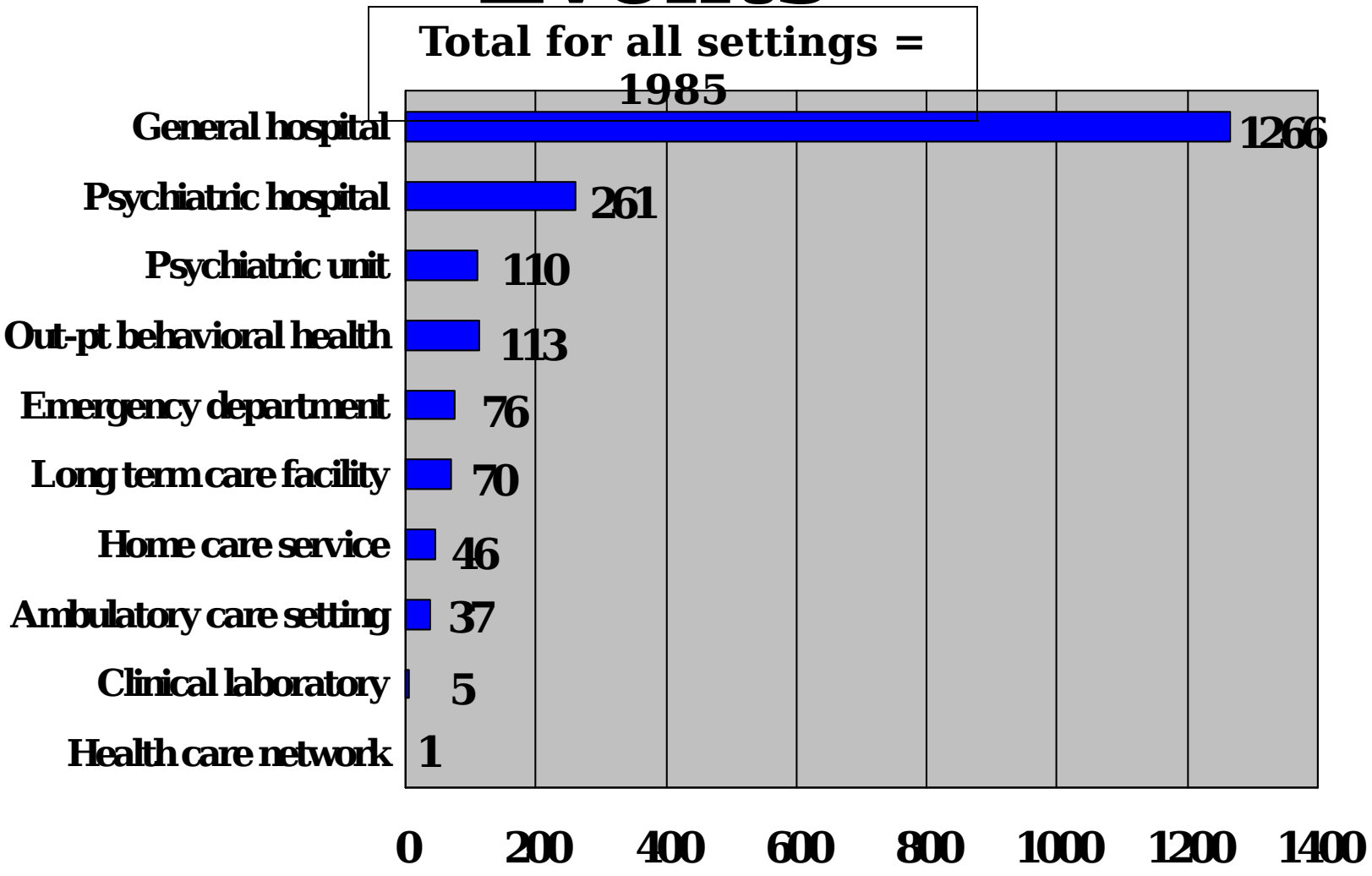
Total "Reviewed" Events by State



Sources of Sentinel Event Information



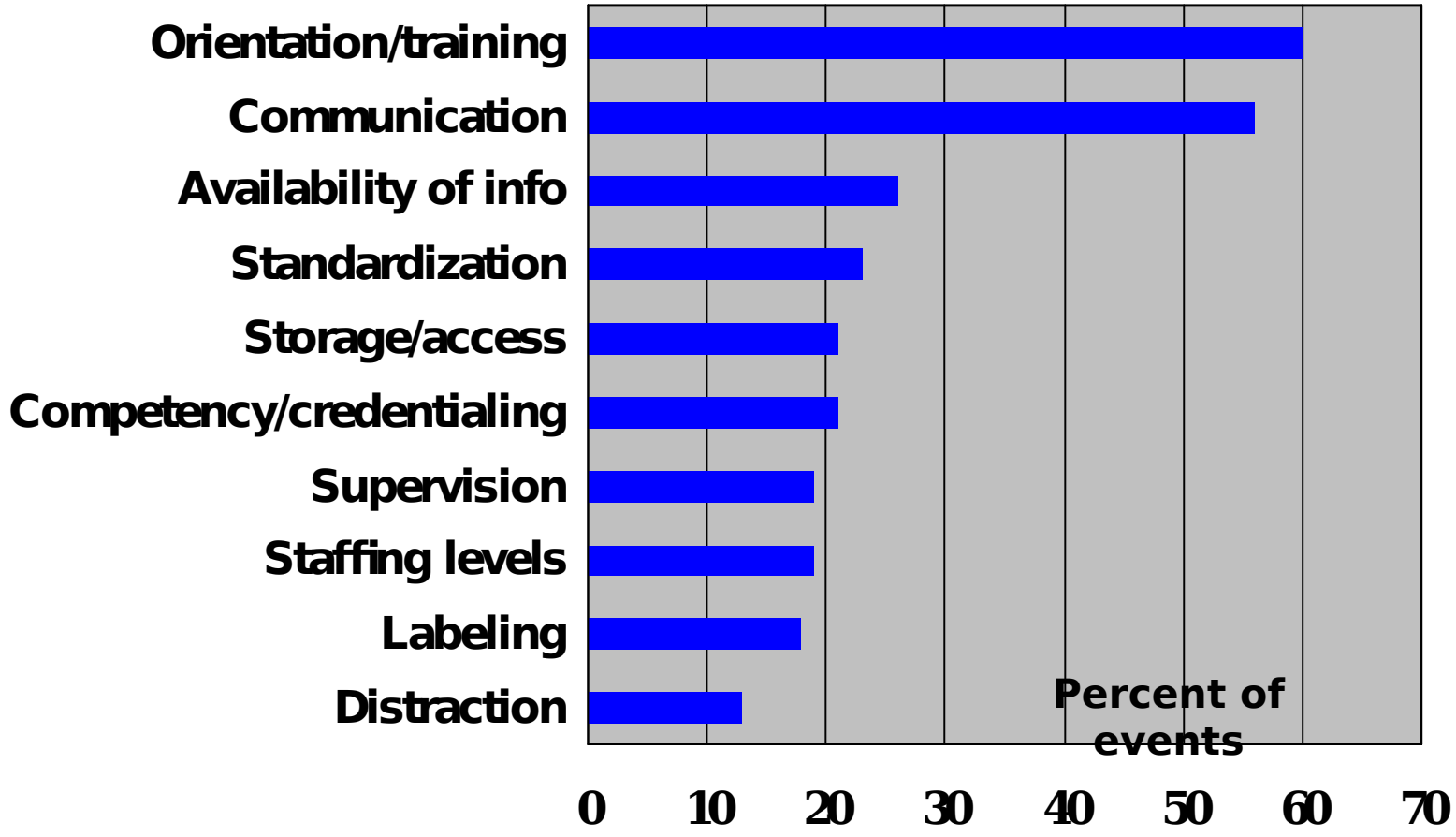
Settings of the Sentinel Events



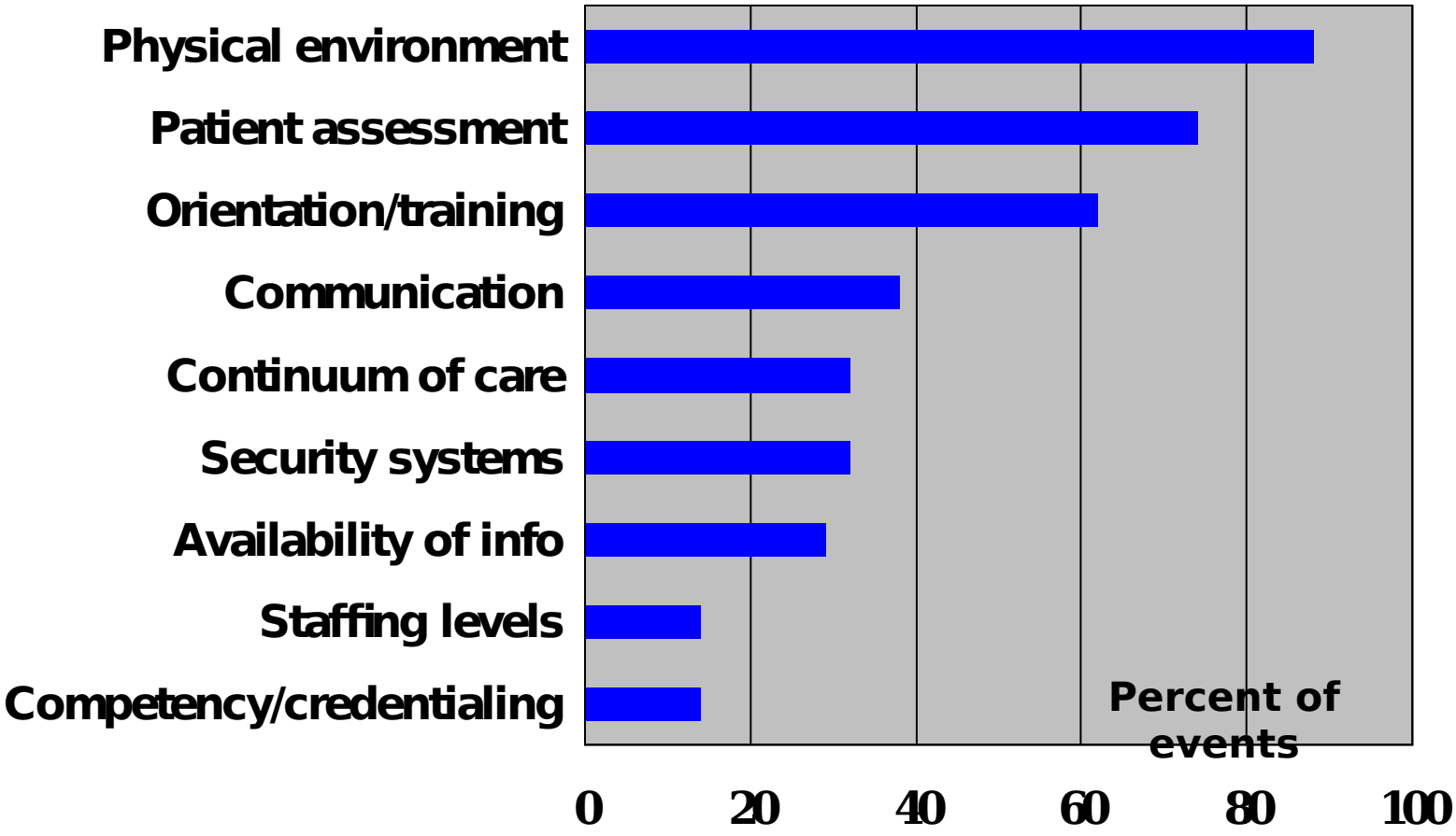
Accreditation Outcomes Following Sentinel Events

- Prior to October 1996:
  - 27 organizations = continued accreditation
  - 14 organizations = conditional accreditation
  - 2 organizations = denied accreditation
- October 1996 through March 1998:
  - 37 organizations = Accreditation Watch
  - 139 organizations = continued accreditation
  - 2 organizations = preliminary nonaccreditation
- Since March 1998:
  - 12 organizations = Accreditation Watch
  - 1514 organizations = continued accreditation

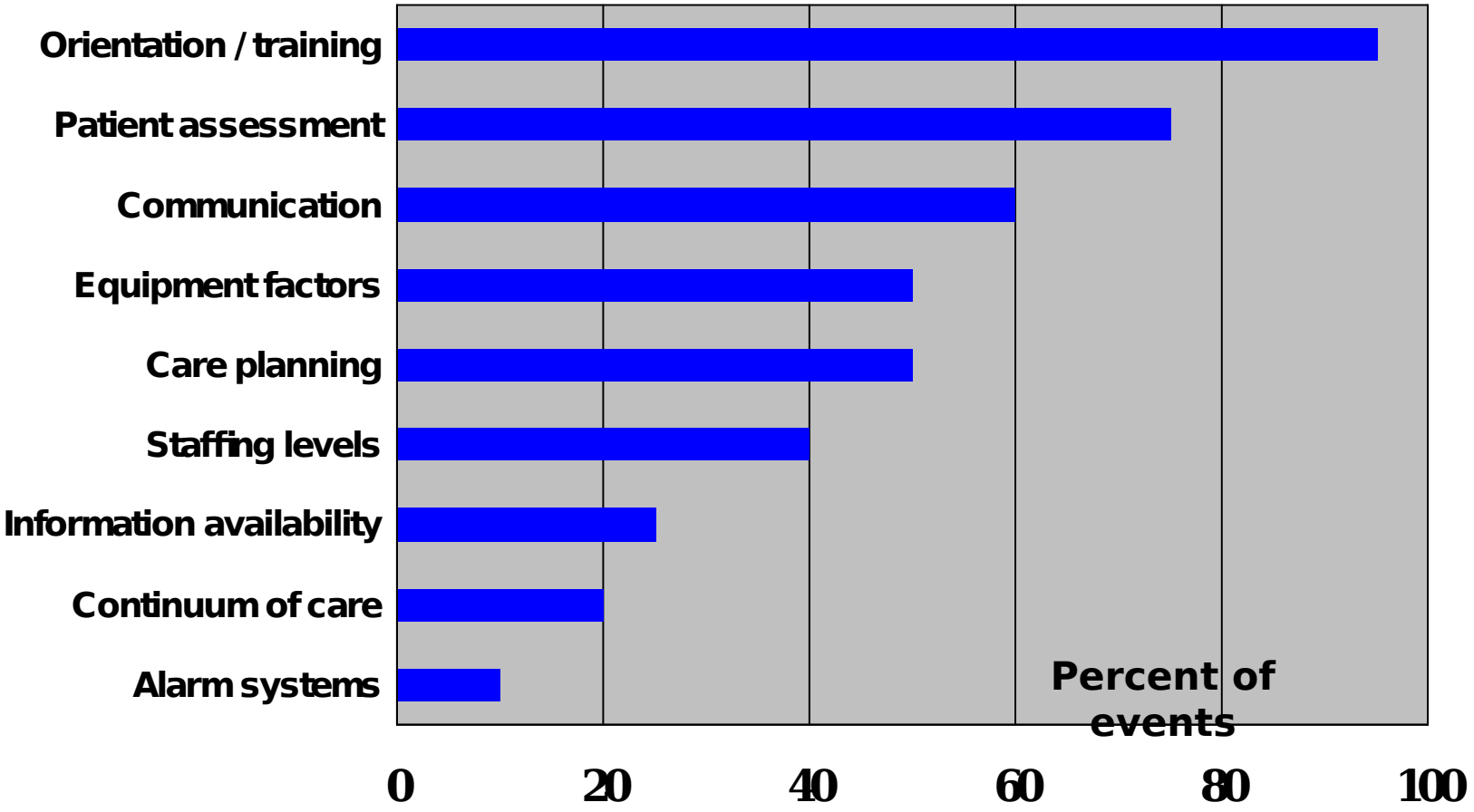
Root Causes of Medication Errors



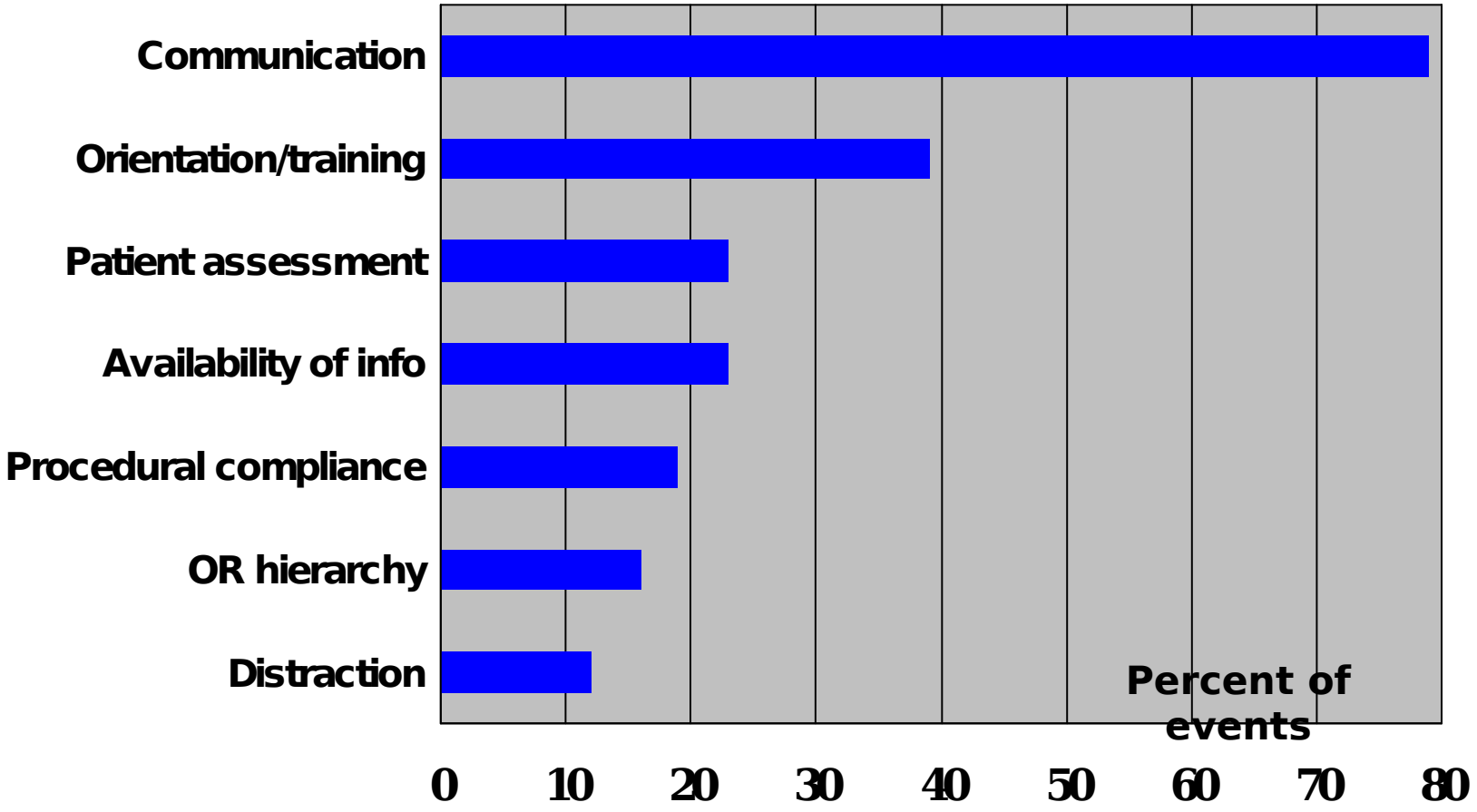
Root Causes of Inpatient Suicides



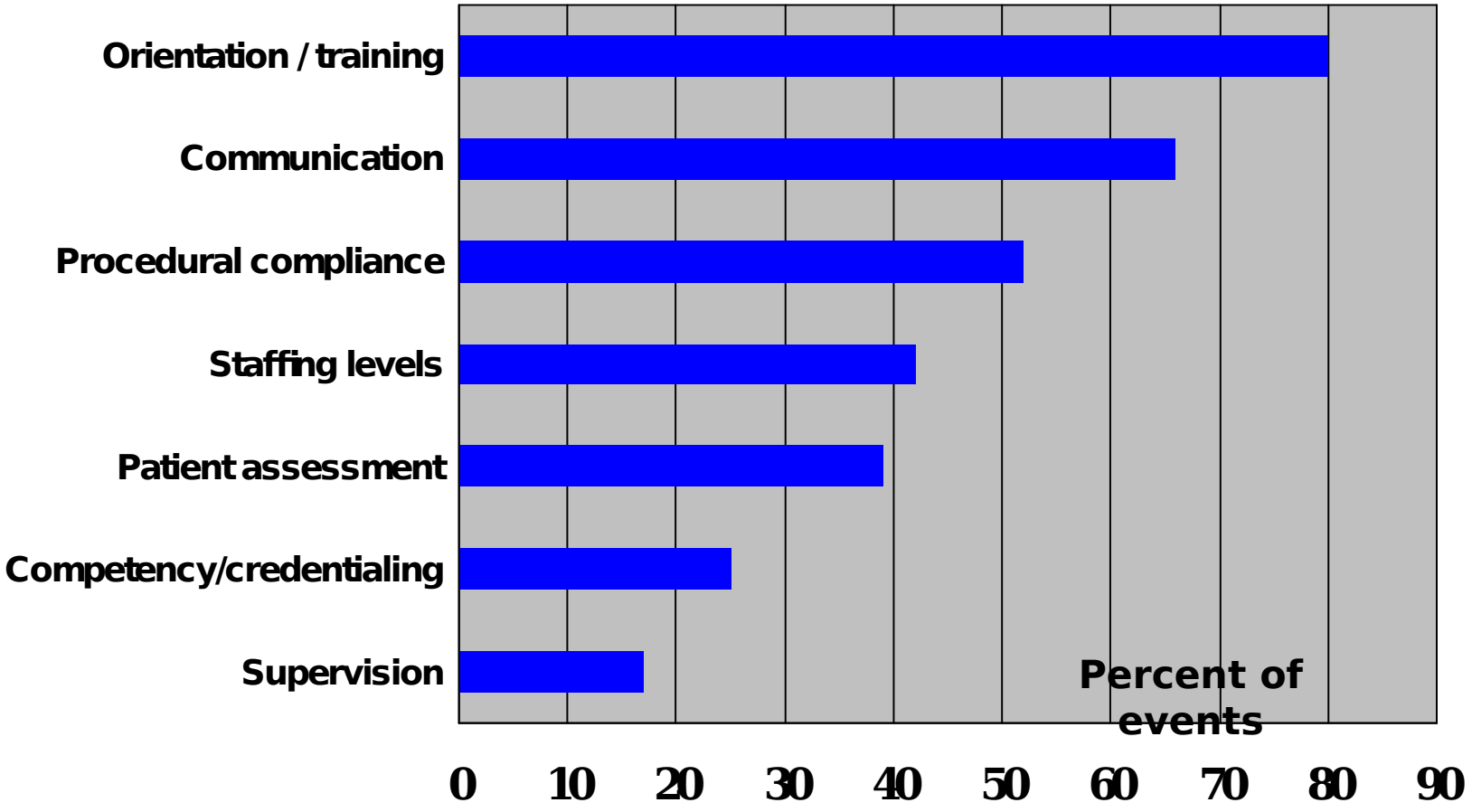
Root Causes of Restraint Deaths



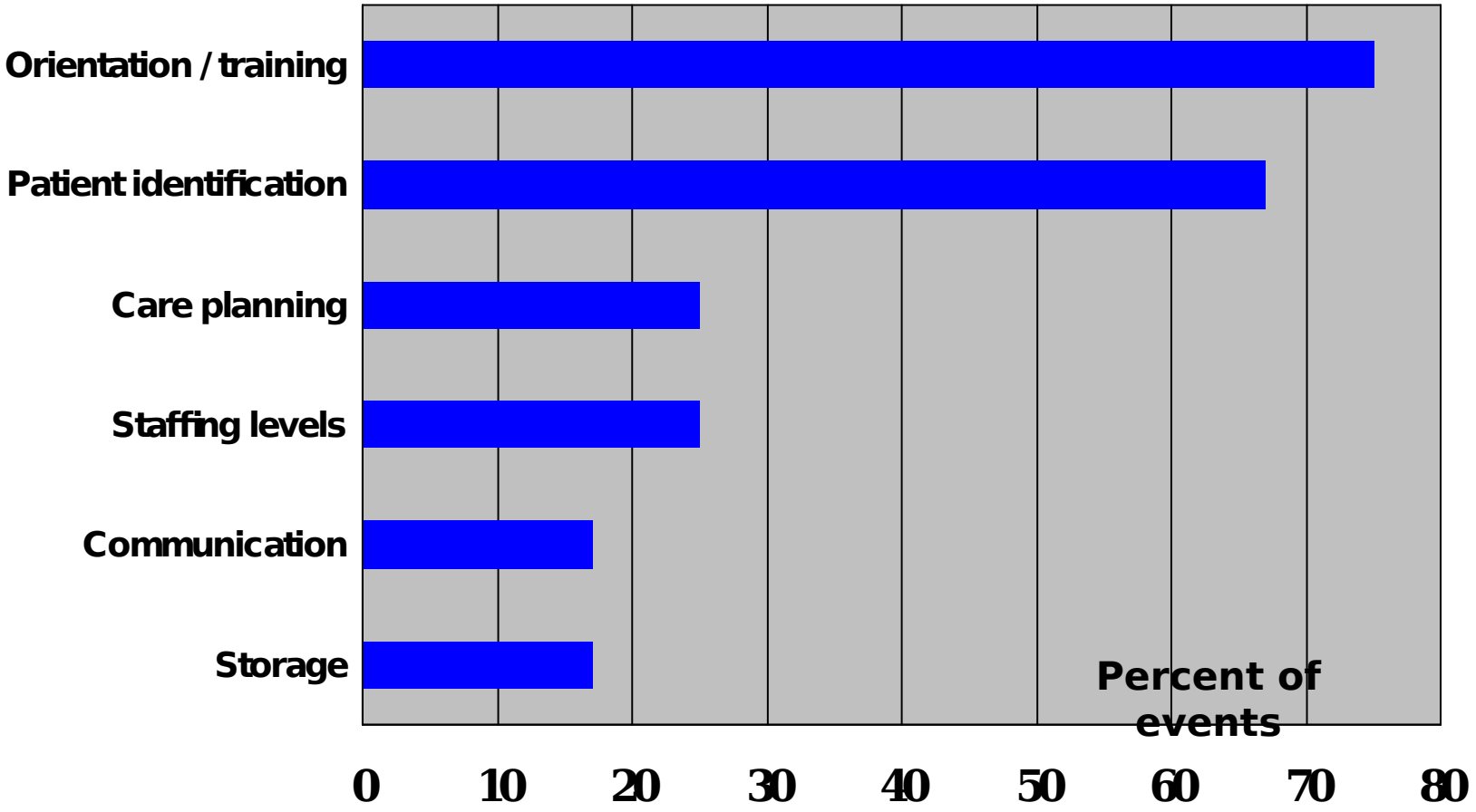
Root Causes of Wrong Site Surgery



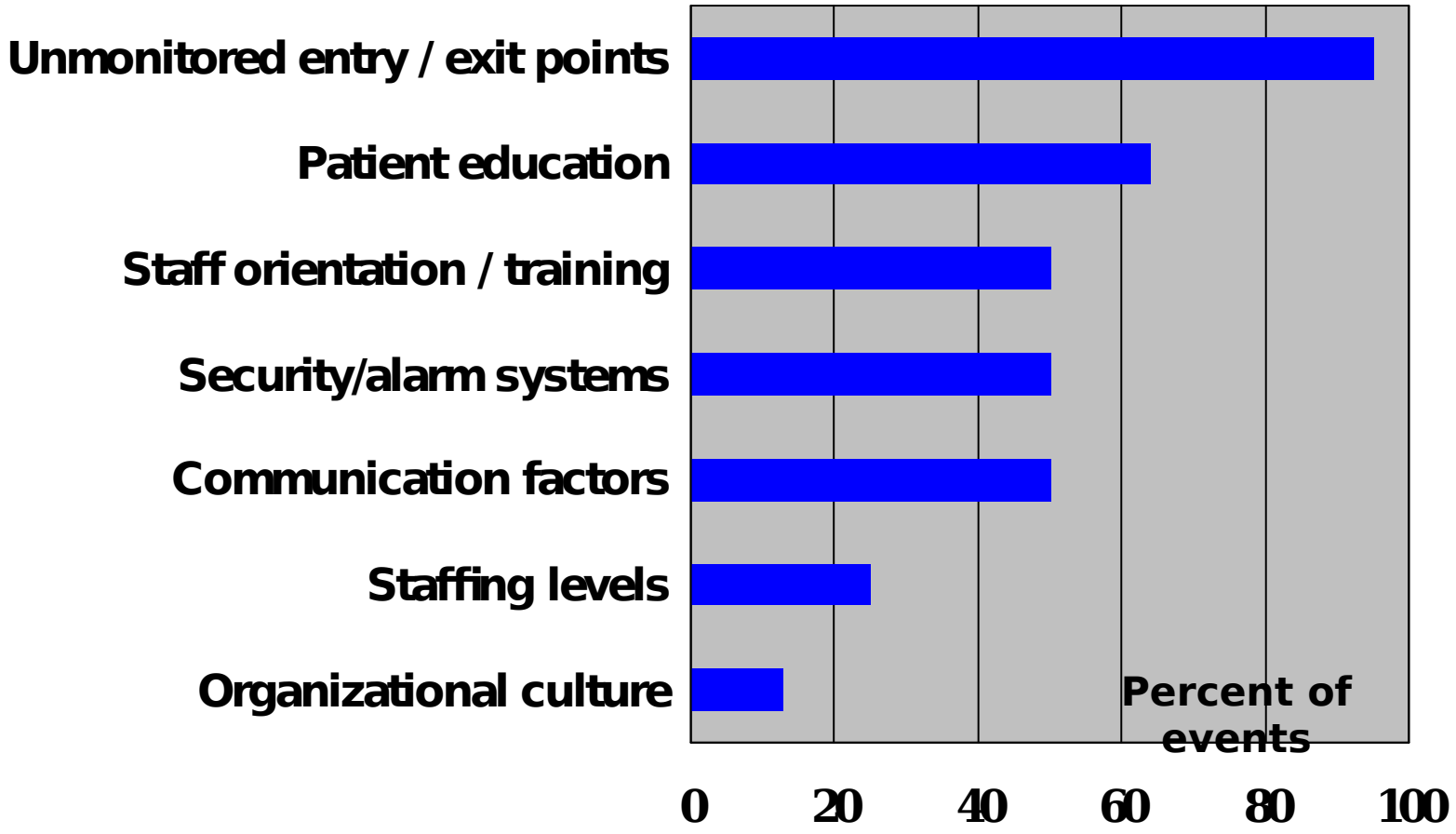
Root Causes of Op/Post-op Events



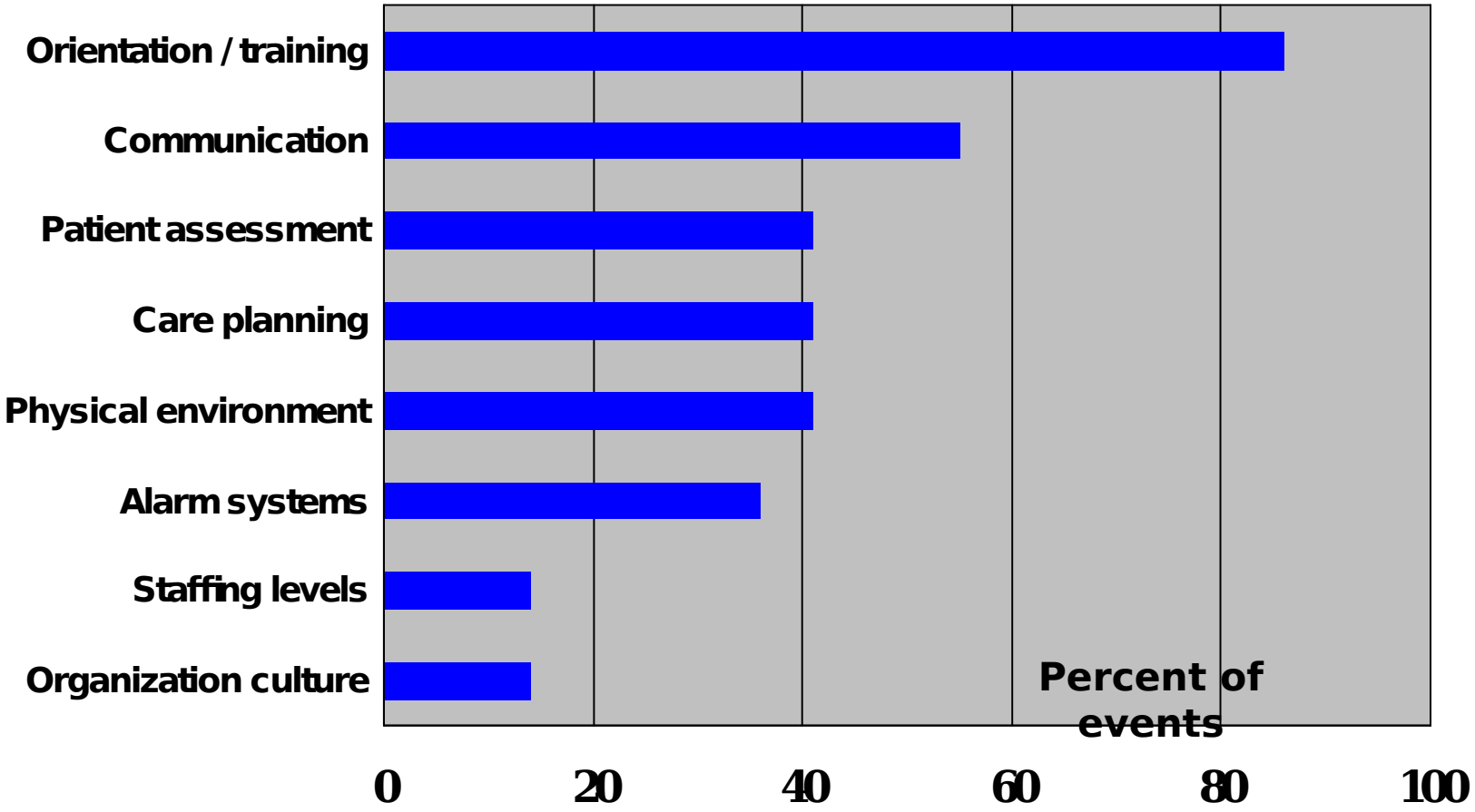
Root Causes of Transfusion Events



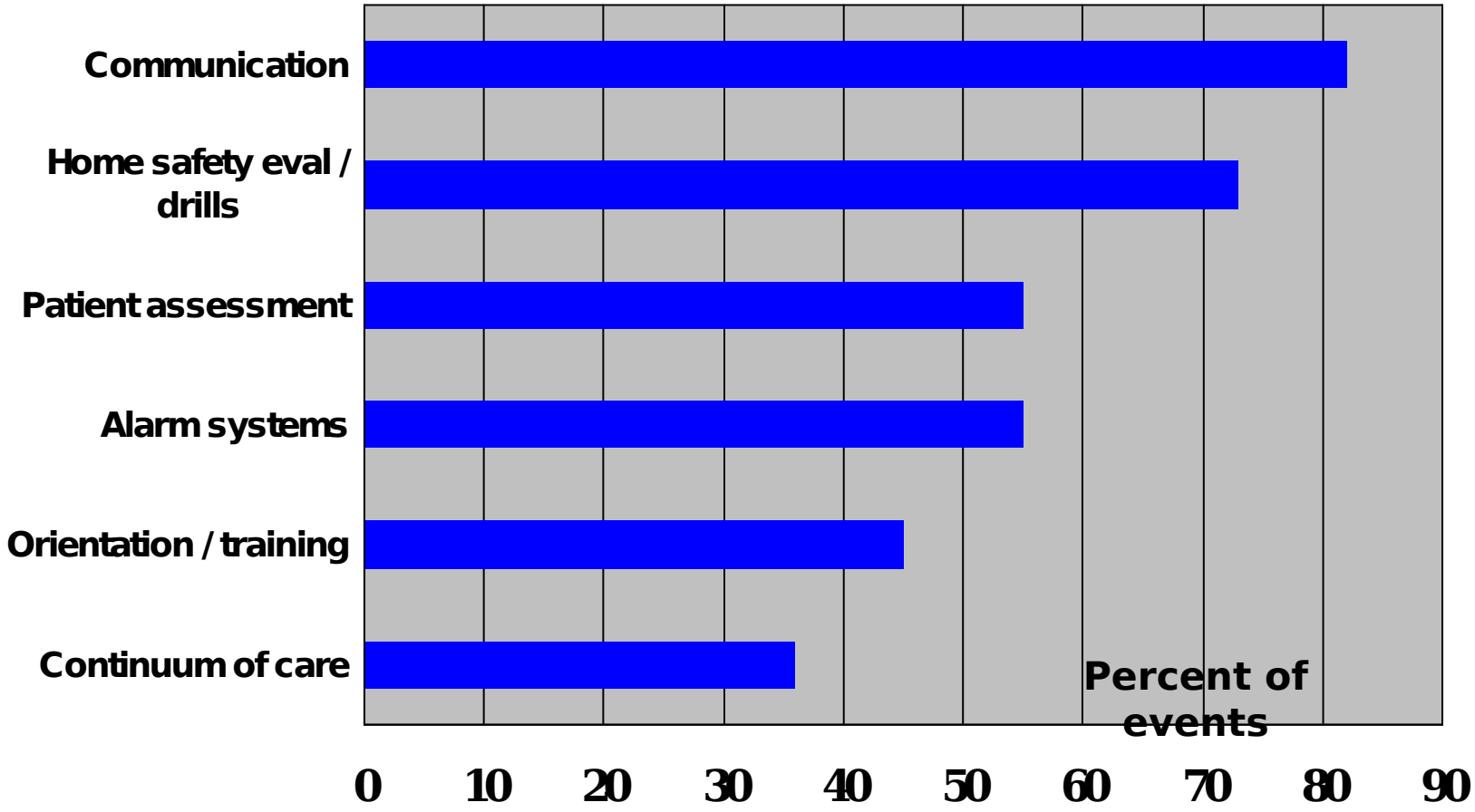
Root Causes of Infant Abductions



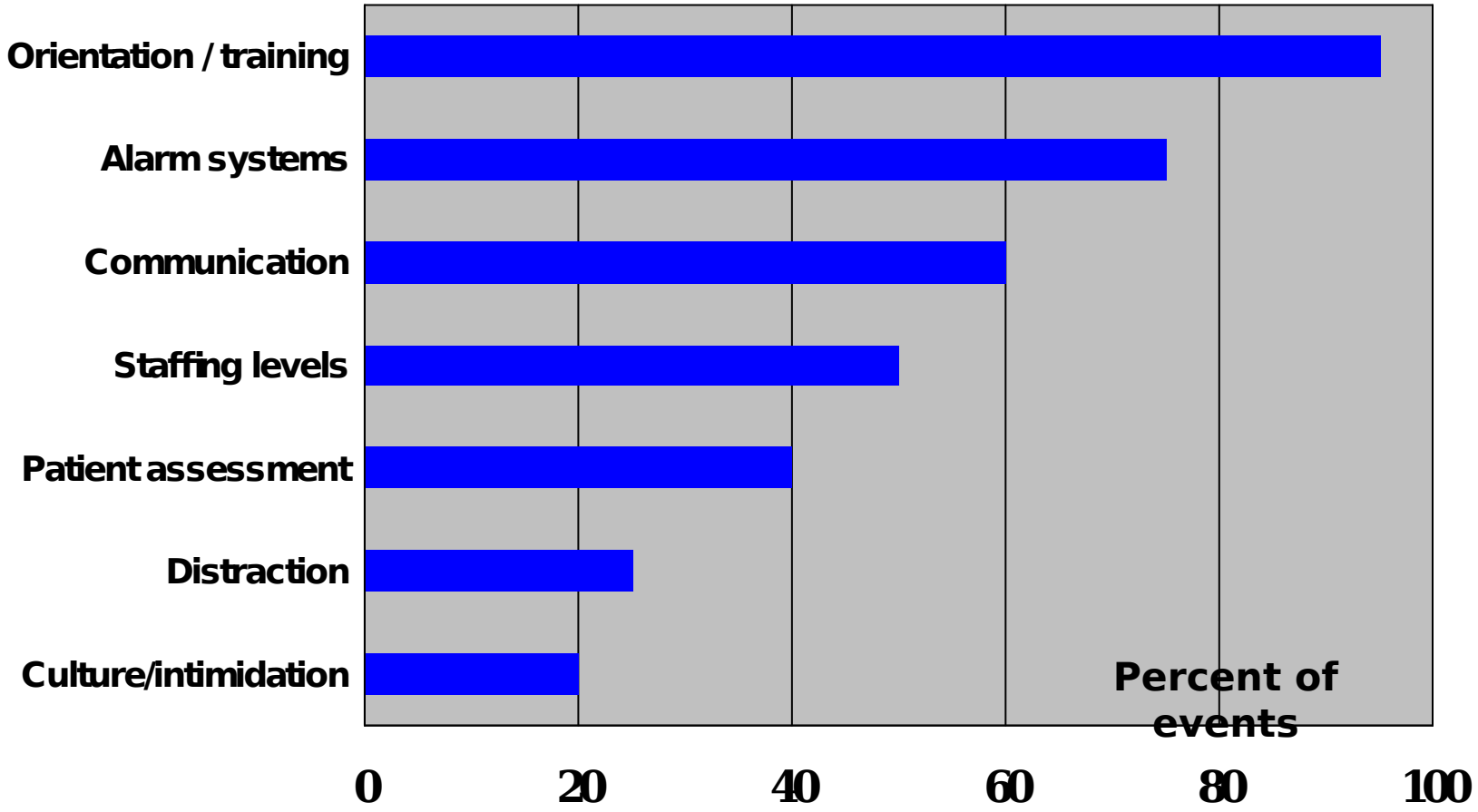
Root Causes of Patient Falls



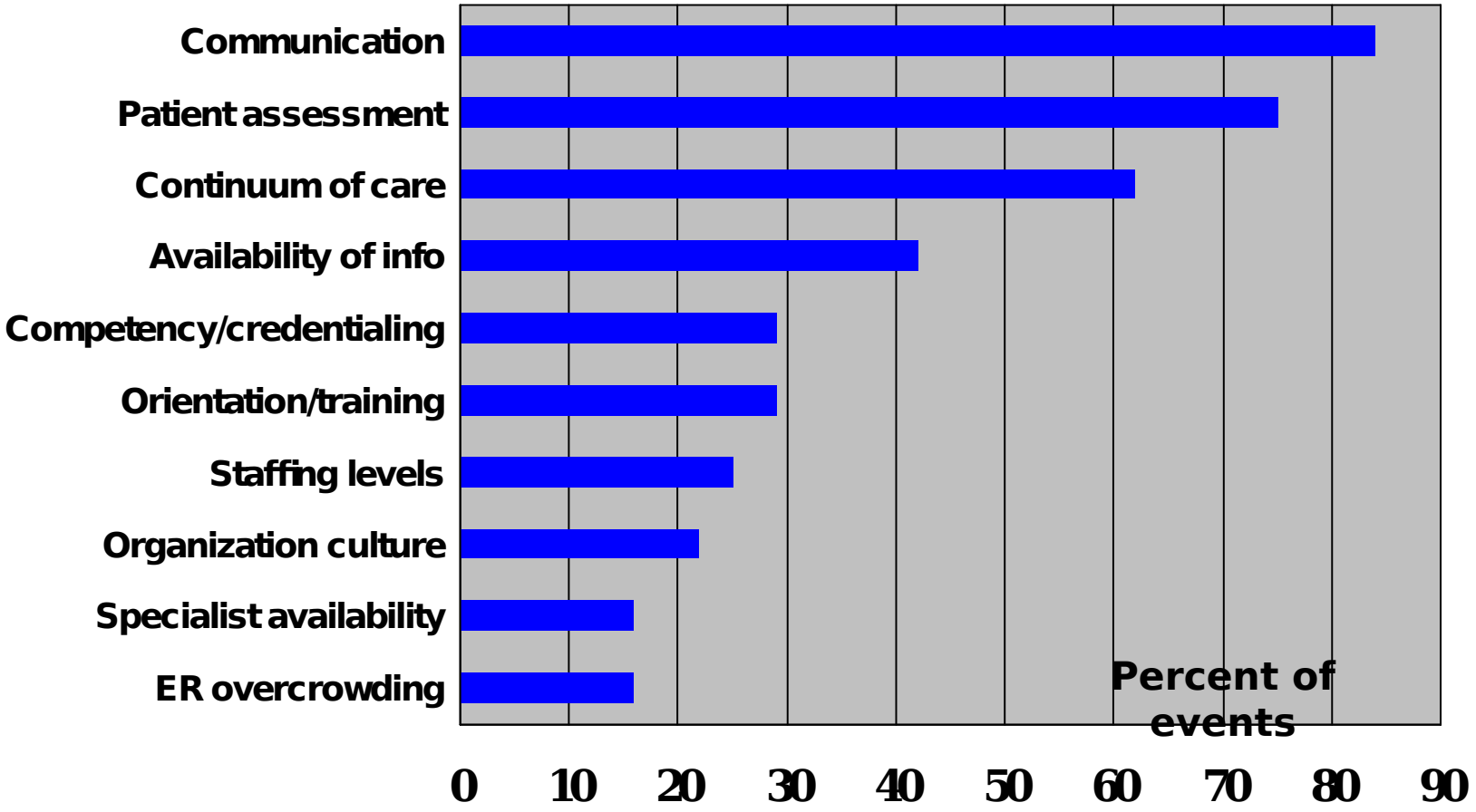
Root Causes of Home Care Fires



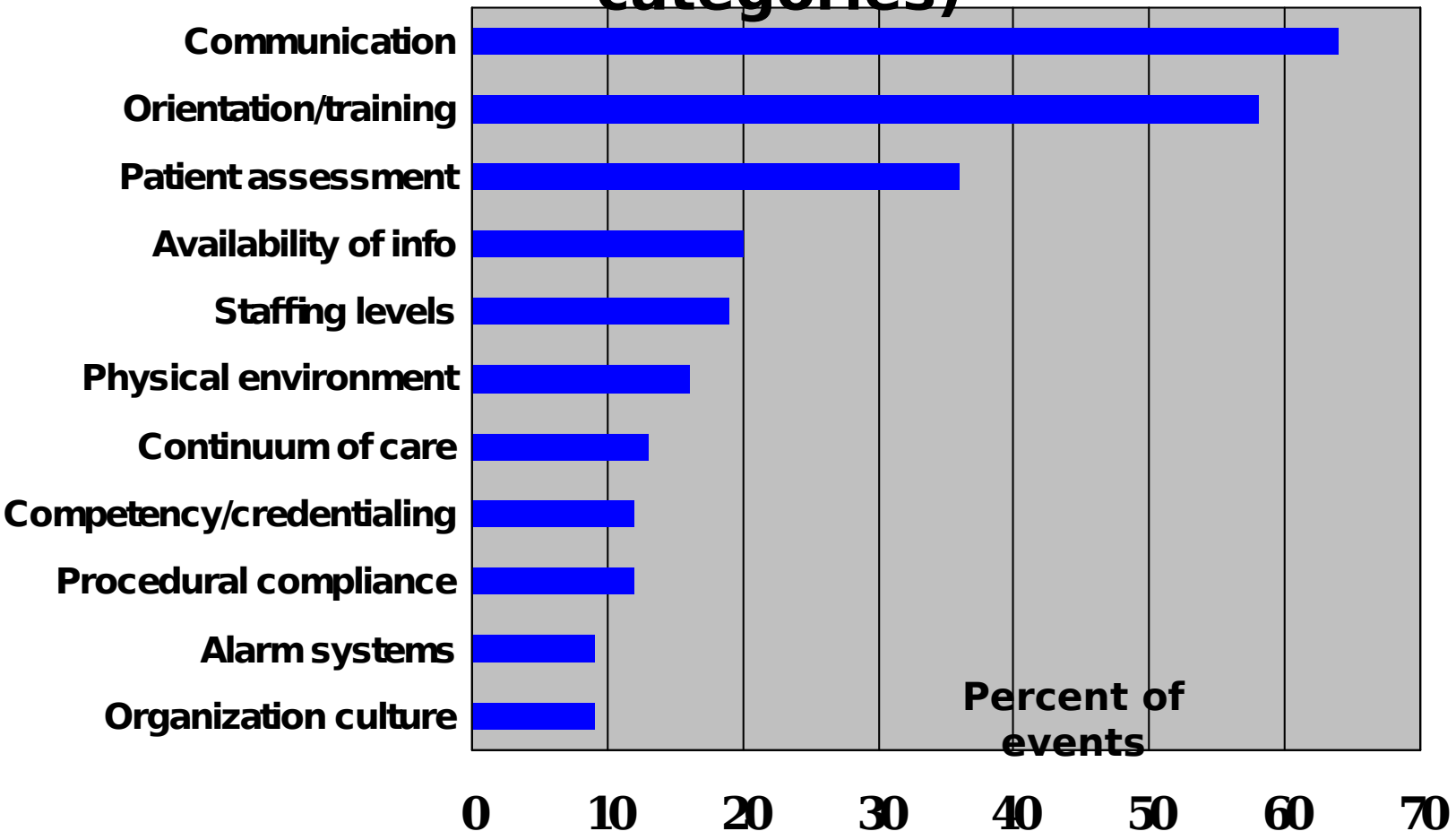
Root Causes of Ventilator Events



Root Causes of Delays in Treatment



Root Causes of Sentinel Events (All categories)



Communication as a Root Cause

- Mode of communication
  - Oral (55%)
  - Written (35%)
  - Electronic (10%)
- Participants
  - Among staff (60%)
  - With or among physicians (25%)
  - With patient or family (15%)
- Other communication issues
  - Transcription
  - Change-of-shift report
  - Paging systems

SENTINEL EVENT ***ALERT***

Joint Commission
on Accreditation of Healthcare Organizations

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Oakbrook Terrace, IL 60181
Phone: (630) 792-5800

A publication of the Joint Commission on Accreditation of Healthcare Organizations

Issue One
2-27-98

"*The way to prevent tragic deaths from accidental intravenous injection of concentrated KCl is excruciatingly simple - -organizations must take it off the floor stock of all units. It is one of the best examples I know of a 'forcing function' -- a procedure that makes a certain type of error impossible.*"
Lucian L. Leape, M.D.

New Publication

We are pleased to introduce the first issue of *Sentinel Event Alert*, a periodic publication dedicated to providing important information relating to the occurrence and management of sentinel events in Joint Commission-accredited health care organizations. *Sentinel Event Alert*, to be published when appropriate as suggested by trend data, will provide ongoing communication regarding the Joint Commission's Sentinel Event Policy and Procedures, and most importantly, information about sentinel event prevention. It is our expectation and belief that in sharing information about the occurrence of sentinel events, we can ultimately reduce the frequency of medical errors and other adverse events.

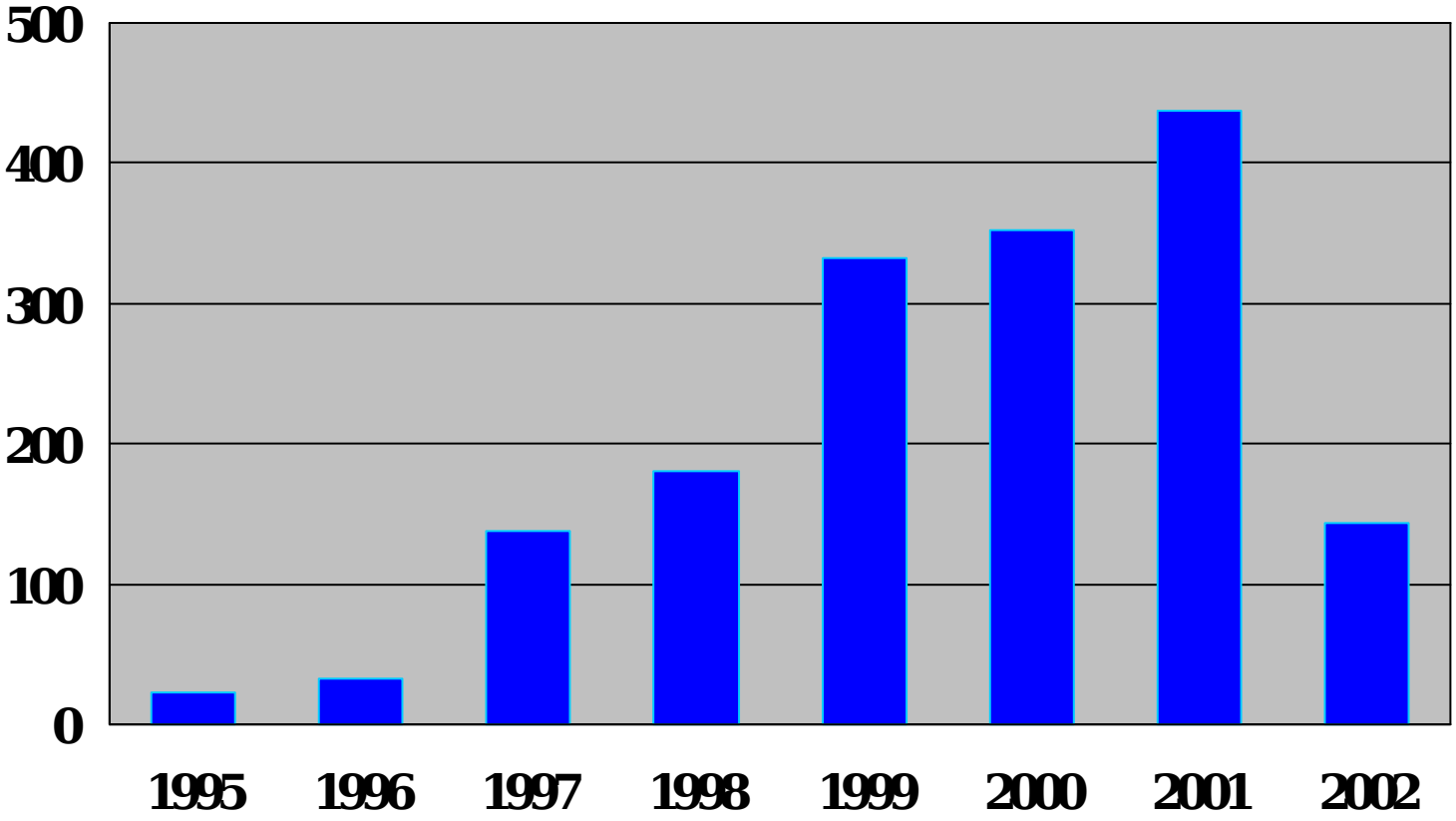
Medication Error Prevention -- Potassium Chloride

In the two years since the Joint Commission enacted its Sentinel Event Policy, the Accreditation Committee of the Board of Commissioners has reviewed more than 200 sentinel events. The most common category of sentinel events was medication errors, and of those, the most frequently implicated drug was **potassium chloride (KCl)**. The Joint Commission has reviewed 10 incidents of patient death resulting from misadministration of

Sentinel Event Alert

1. Potassium chloride
2. Policy issues
3. Policy issues
4. Policy issues
5. Policy issues
6. Wrong site surgery
7. Suicide
8. Restraint deaths
9. Infant abductions
10. Transfusion errors
11. High Alert Medications
12. Op/post-op complications
13. Impact of *SE Alert*
14. Fatal Falls
15. Infusion Pumps
16. Proactive risk reduction
17. Home fires (O^2 therapy)
18. Kernicterus
19. Look-alike, sound-alike drugs
20. Kreutzfeldt-Jakob disease
21. Medical gas mix-ups
22. Needles & sharps injuries
23. Dangerous abbreviations
24. Wrong-site surgery #2
25. Ventilator-related events
26. Delays in treatment
27. Bed Rail Entrapment Deaths
28. Infection Control Sentinel Events
29. Preventing Surgical Fires

Sentinel Event Trends: All Reviewed Events



New and Revised Joint Commission Standards in Support of Patient Safety Programs in Hospitals

Implemented July 1, 2001

- Leadership
- Performance Improvement
- Information Management
- Human Resource Management
- Patient Rights
- Patient and Family Education

New and Revised Standards for Patient Safety

Requirement for a hospital-wide patient safety program [LD.5 crosswalks to LD 4.40]

- Not a new structure
- Designate individual(s) to manage program
- Define scope of program
- Integrate & coordinate throughout the hospital
- Systems for internal and external reporting
- Mechanisms for responding to adverse events
- Mechanisms for conducting proactive risk reduction
- Support for staff involved in a sentinel event
- Annual report to the governing body

Leadership Standard for Management of Sentinel Events

LD.5.1 crosswalks to PI

Leaders ensure that the processes for identifying and managing sentinel events are defined and implemented.

Intent:

- Establish an organizational culture conducive to identifying, reporting, analyzing and preventing sentinel events
- Working definition of “sentinel event”
- Mechanism for reporting
- Process for root cause analysis
- Mechanisms for implementing risk reduction

New and Revised Standards for Patient Safety

- New “LD” requirements for proactive risk assessment and risk reduction [LD.5.2 crosswalks to PI]
  - Based on available risk-related information
  - Focused on high-risk activities selected by the organization
  - “Failure mode and effects” analysis (FMEA)

New and Revised Standards for Patient Safety

- Performance Improvement
  - Collect data (PI.3.1 crosswalks to PI1.10) on
    - Patients' views on how to improve patient safety
    - Staff opinions & suggestions for improving patient safety
    - Staff willingness to report errors
- Information Management
  - To promote effective communication among participants in health care processes [IM.1 crosswalks to IM 1.10 and IM.5 crosswalks to IM 3.10]

New and Revised Standards for Patient Safety

- Other standards-based functions, including
  - Human Resource Management (job-specific safety O&T; team training; staffing effectiveness) [HR.4 crosswalks to HR 2.10, HR.2 crosswalks to HR 1.10 & 1.20]
  - Patient and Family Education (patient's role in improving patient safety) [PF.3.7 crosswalks to RI 3.10]
  - Patient Rights (informing patients about the outcomes of their care) [RI.1.2.2 to RI 2.90]

RI.1.2.1 crosswalks to RI 2.40 & 2.60 – Informed consent

- The standard:
  - Informed consent is obtained

- Intent of the standard:
  - Staff explain any proposed treatments or procedures to the patient … including
    - Potential benefits and drawbacks
    - The likelihood of success
    - Possible results of non-treatment
    - Any significant alternatives

RI.1.2.2 crosswalks to RI 2.90 – Disclosing outcomes

- **<u>The standard</u>:**

  Patients are informed about the outcomes of their care, including unanticipated outcomes

- **<u>Intent of the standard</u>:**

  At a minimum, the patient and, when appropriate, the patient's family are informed about

  - outcomes of care that the patient (or family) must be knowledgeable about in order to participate in current and future decisions affecting the patient's care; and
  - unanticipated outcomes of care that relate to sentinel events considered reviewable by the Joint Commission. The responsible licensed independent practitioner (LIP) or his or her designee informs the patient (and when appropriate, the patient's family) about these outcomes of care.

Interpretation of RI.1.2.2 (crosswalk RI 2.90)

- The standard does not require informing patients about errors

  (This is up to the individual hospital)

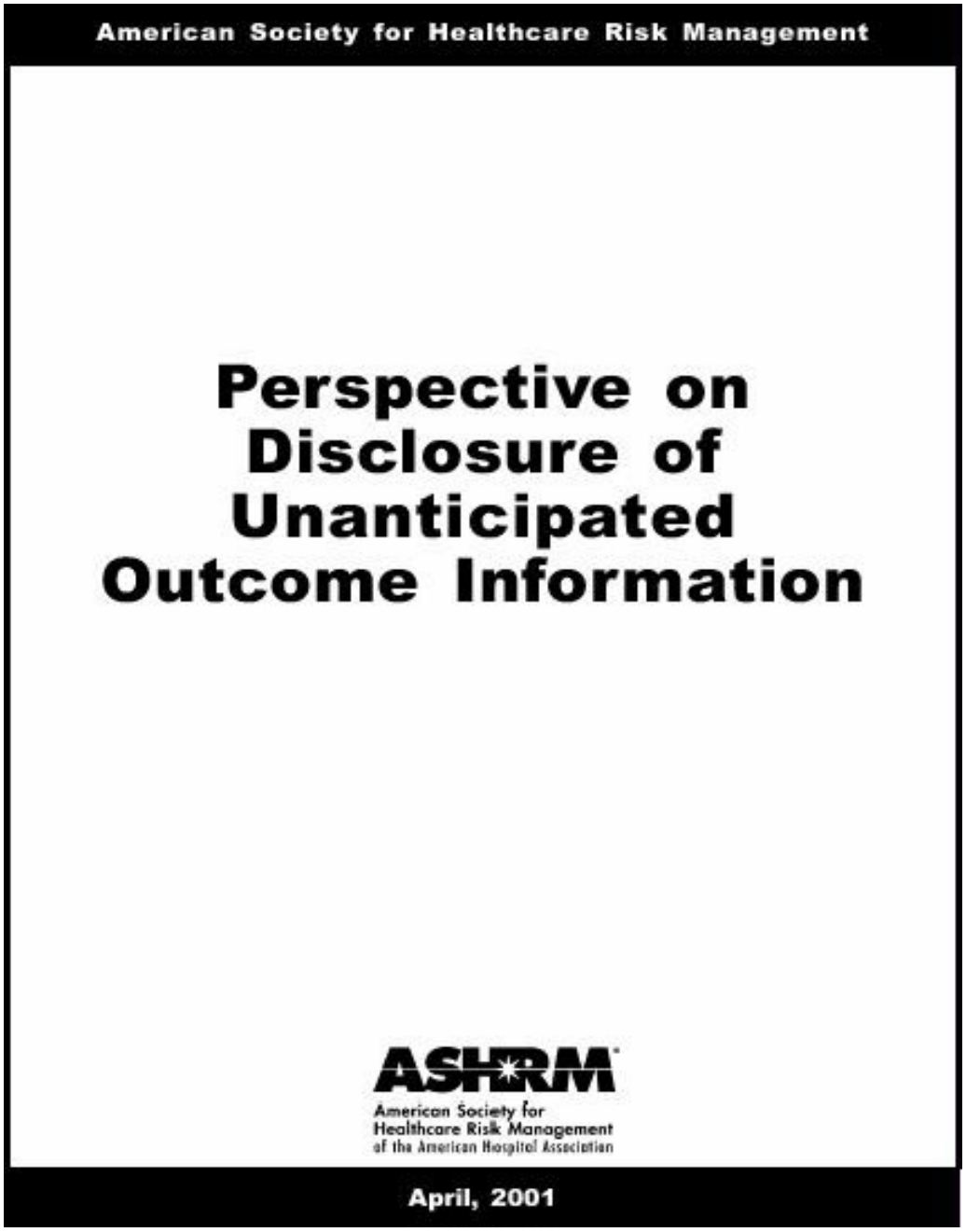
- The standard does not require any specific documentation

  (Neither a written policy nor documentation of the conversation with the patient)

- Consultative advice: All patients should be informed of all outcomes of their care (anticipated or otherwise)

- The survey process will focus on the hospital's process for informing patients about unanticipated outcomes
  - At a minimum, those outcomes that are reviewable under the Sentinel Event Policy

For additional detail on implementation of a policy on disclosure of outcomes, consistent with the requirements of this standard:


American Society for Healthcare Risk Management
Perspective on Disclosure of Unanticipated Outcome Information
ASHRM
American Society for Healthcare Risk Management of the American Hospital Association
April, 2001

To “Score 1” in a JCAHO Survey

- In the Leadership Interview, the hospital’s leaders should be able to articulate ...
  - Their intended process for informing patients about the outcomes of their care
  - How they ensure consistent implementation of this process

To “Score 1” in a JCAHO Survey

- During the patient care unit visits, the direct caregivers (physicians, nurses, etc.) should be able to describe ...
  - The hospital’s process for informing patients
  - Whether it is consistently implemented
  - How it is implemented in the case of a serious adverse outcome (e.g., sentinel event)

More about the Survey Process

- Surveyors will not ask patients what they know about their outcomes

- Surveyors will review
  - any written policies on disclosure to patients
  - documentation of conversations with patients
  - any information that the leaders rely on to be sure that the process is being implemented consistently.

Hospital Response to Recommendations in *Sentinel Event Alert*

- All accredited hospitals are expected to review each issue of *Sentinel Event Alert*
- As relevant to their services, hospitals must implement the recommendations in *SE Alert*

OR

- Implement a reasonable alternative (at least as good)

OR

- Provide a reasonable explanation for doing neither

National Patient Safety Goals

- Each year, Patient Safety Goals will be identified from topics published in *Sentinel Event Alert*
- One or two specific recommendations for each of the Goals will be identified for survey the following year
- The Goals and their recommendations will be published by mid-year
- Selection of the Goals and recommendations will be guided by a panel of experts: the *Sentinel Event Alert* Advisory Group

The *Sentinel Event Alert* Advisory Group

- Nationally recognized experts in patient safety
- Systems engineers with practical knowledge of root cause analysis, failure mode & effects analysis, human factors engineering, etc.
- Individuals with hands-on experience in health care organizations, representative of the types & sizes of organizations and the various patient populations
- Experts in related fields such as pharmaceuticals, information technology, medical equipment, etc.

The *Sentinel Event Alert* Advisory Group

- Assess the evidence for and face validity of *Sentinel Event Alert* recommendations
- Assess the practicality and cost of implementing each of the identified evidence-based recommendations
- Reach consensus on candidates for National Patient Safety Goals
- Assess the comparability of alternatives to the recommendations that are implemented by individual organizations

The JCAHO 2004 National Patient Safety Goals

1. Patient identification
2. Communication among caregivers
3. High-alert medications
4. Wrong-site surgery
5. Infusion pumps
6. Clinical alarm systems
7. Reduce risk of health-care acquired infections

The JCAHO 2004 National Patient Safety Goals

Goal #1: Improve the accuracy of patient identification.

Recommendation #1.a.

Use at least 2 patient identifiers (not the patient's room number)

Recommendation #1.b.

Verification "time out" in the O.R.

The JCAHO 2004 National Patient Safety Goals

Goal #2: Improve the effectiveness of communication among caregivers.

Recommendation #2.a.

"Read-back" of verbal/telephone orders

Recommendation #2.b.

Standardize abbreviations, symbols, etc.

The JCAHO 2004 National Patient Safety Goals

Goal #3: Improve the safety of using high-alert medications.

Recommendation #3.a.

Remove concentrated electrolytes from patient care units

Recommendation #3.b.

Standardize/limit drug concentrations

The JCAHO 2004 National Patient Safety Goals

Goal #4: Eliminate wrong-site, wrong-patient, wrong-procedure surgery.

Recommendation #4.a.

Pre-op verification process

Recommendation #4.b.

Mark the surgical site

The JCAHO 2004 National Patient Safety Goals

Goal #5: Improve the safety of using infusion pumps.

Recommendation #5.a.

Free-flow protection on all general-use and PCA intravenous infusion pumps.

The JCAHO 2004 National Patient Safety Goals

Goal #6: Improve the effectiveness of clinical alarm systems.

Recommendation #6.a.

Regular preventive maintenance and testing

Recommendation #6.b.

Assure alarms are active and audible

The JCAHO 2004 National Patient Safety Goals

Goal #7: Reduce the Risk of health care acquired infections

Recommendation #7.a.

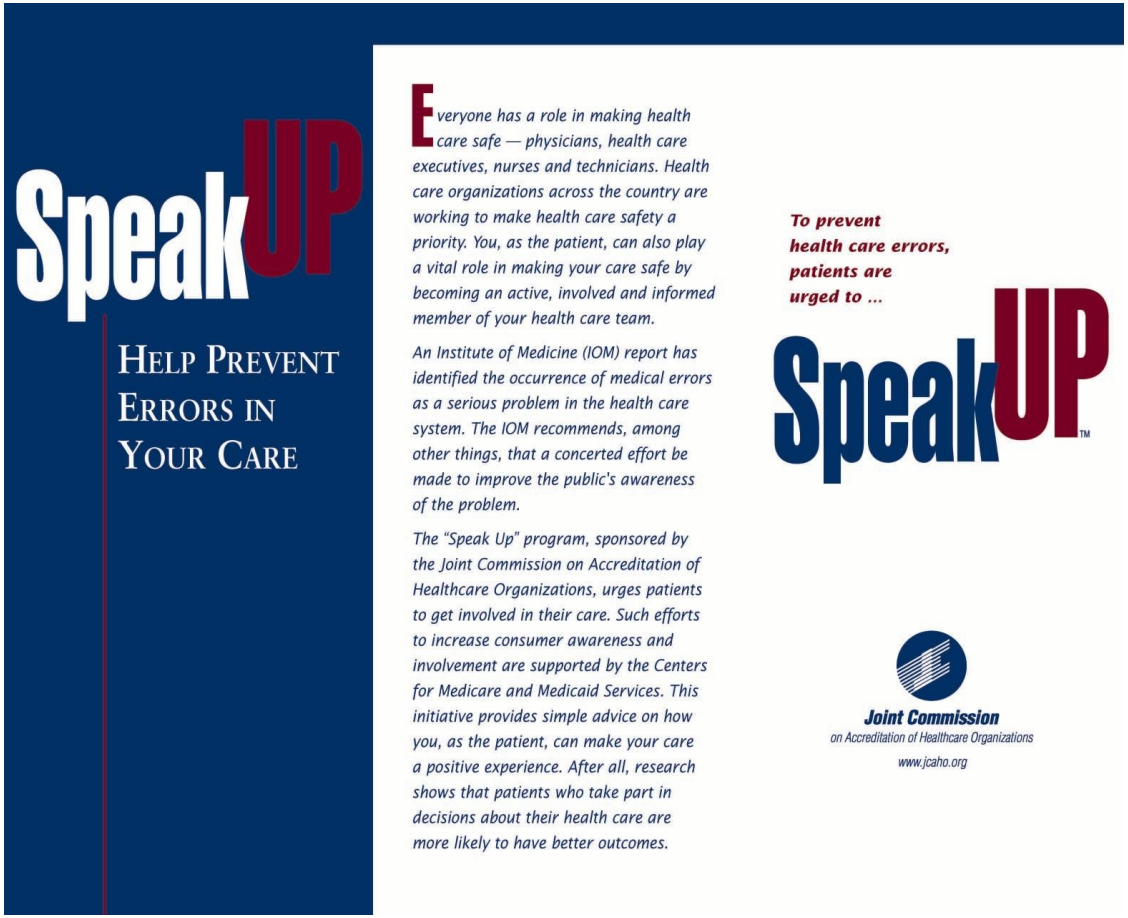
Comply with CDC hand-hygiene guidelines

Recommendation #7.b.

Manage as SE all identified cases of unanticipated death or major permanent lost of function associated with health care-acquired infection

Surveying and Scoring the National Patient Safety Goals

- All accreditation programs
- All full surveys and unannounced surveys
- Must implement all Goals/Recs that are relevant to services provided, or implement an acceptable alternative(s)
- Alternatives must be acceptable to JCAHO
- Failure to address one or more will result in a single “Special Requirement for Improvement beginning 2004”


SpeakUP
Help Prevent Errors in Your Care
Everyone has a role in making health care safe — physicians, health care executives, nurses and technicians. Health care organizations across the country are working to make health care safety a priority. You, as the patient, can also play a vital role in making your care safe by becoming an active, involved and informed member of your health care team.
An Institute of Medicine (IOM) report has identified the occurrence of medical errors as a serious problem in the health care system. The IOM recommends, among other things, that a concerted effort be made to improve the public's awareness of the problem.
The "Speak Up" program, sponsored by the Joint Commission on Accreditation of Healthcare Organizations, urges patients to get involved in their care. Such efforts to increase consumer awareness and involvement are supported by the Centers for Medicare and Medicaid Services. This initiative provides simple advice on how you, as the patient, can make your care a positive experience. After all, research shows that patients who take part in decisions about their health care are more likely to have better outcomes.
To prevent health care errors, patients are urged to ...
SpeakUP™
Joint Commission
on Accreditation of Healthcare Organizations
www.jcaho.org

Organizations can order campaign buttons that can be worn by staff.

Brochures can be ordered that have a blank panel to allow for information about the organization, its commitment to patient safety, and the organization logo.

SpeakUP

To help prevent health care errors, patients are urged to:

Speak up if you have questions or concerns, and if you don't understand, ask again. It's your body and you have a right to know.

Pay attention to the care you are receiving. Make sure you're getting the right treatments and medications by the right health care professionals. Don't assume anything.

Educate yourself about your diagnosis, the medical tests you are undergoing, and your treatment plan.

Ask a trusted family member or friend to be your advocate.

Know what medications you take and why you take them. Medication errors are the most common health care mistakes.

Use a hospital, clinic, surgery center, or other type of health care organization that has undergone a rigorous on-site evaluation against established, state-of-the-art quality and safety standards, such as that provided by JCAHO.

Participate in all decisions about your treatment. You are the center of the health care team.

SpeakUP Brochure

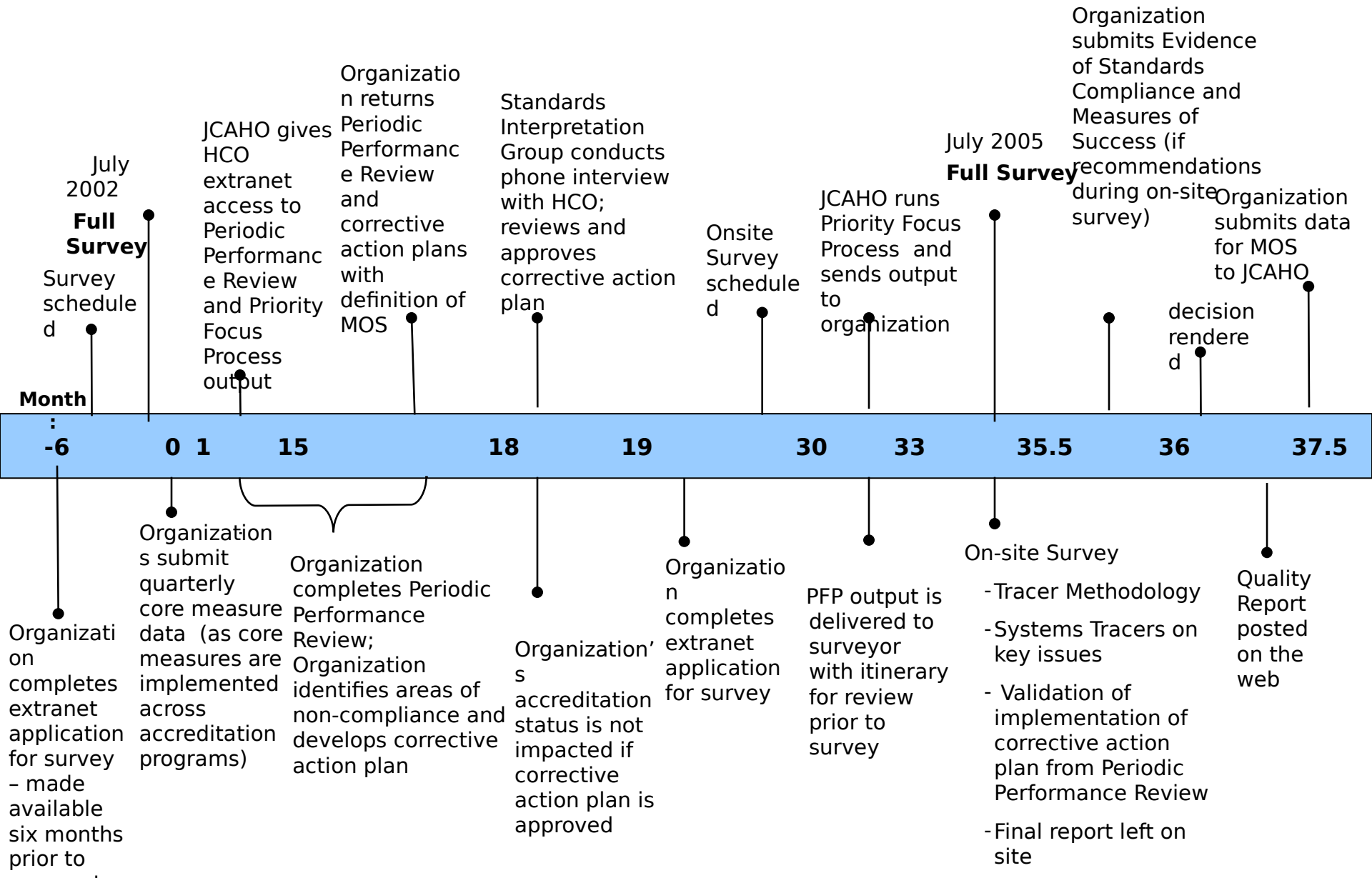
- All accredited health care organizations were provided information about the SpeakUP campaign and samples of the brochure and buttons.
- The brochures are tailored to specific types of organizations including hospitals, nursing homes, home care agencies, laboratories, behavioral health care organizations, networks.
- The brochure has a blank panel that allows health care organizations to add their own patient safety messages. Organizations may also order buttons for their staff and posters.
- Church groups, advocacy groups and pharmaceutical companies are printing and distributing brochures.

Standards and Survey Process

“All standards are patient safety standards??

See crosswalk handouts

Shared Visions—New Pathways: Triennial Accreditation Cycle
Example of HCO Surveyed in July 2002


July 2002
Full Survey
Survey schedule d
JCAHO gives HCO extranet access to Periodic Performanc e Review and Priority Focus Process output
Organizatio n returns Periodic Performanc e Review and corrective action plans with definition of MOS
Standards Interpretation Group conducts phone interview with HCO; reviews and approves corrective action plan
Onsite Survey schedule d
JCAHO runs Priority Focus Process and sends output to organization
July 2005
Full Survey
Organization submits Evidence of Standards Compliance and Measures of Success (if recommendations during on-site survey)
decision rendere d
Organization submits data for MOS to JCAHO
Month :
-6
0
1
15
18
19
30
33
35.5
36
37.5
Organizati on completes extranet application for survey – made available six months prior to
Organization s submit quarterly core measure data (as core measures are implemented across accreditation programs)
Organization completes Periodic Performance Review; Organization identifies areas of non-compliance and develops corrective action plan
Organization' s accreditation status is not impacted if corrective action plan is approved
Organizatio n completes extranet application for survey
PFP output is delivered to surveyor with itinerary for review prior to survey
On-site Survey
- Tracer Methodology
- Systems Tracers on key issues
- Validation of implementation of corrective action plan from Periodic Performance Review
- Final report left on site
Quality Report posted on the web

Goals: Most importantly…

- Shift the paradigm from survey prep to systems improvement
  - Focus away from the “exam” and “score”
  - Focus toward using the standards to achieve and maintain excellent operational systems

Accomplishing the Goals…..

- Complete review of standards
- Enhanced use of the extranet
- Periodic Performance Review (PPR)
- Priority Focus Process (PFP)
- Continued use of ORYX data
- New survey agenda
- Major surveyor development initiative
- Revised complex organization survey
- New accreditation decision and reporting approach

Improved 2004 Standards

- Standards are more precise and concise statements of performance expectations
- A rationale offers additional text describing the standard's purpose and background
- Elements of performance (EP's) are statements of objective performance expectations scored via simple, objective criteria.
- EP's are the same in the manual, in Periodic Performance Review and in the surveyor's laptop
- Scoring is based on an aggregation of compliance with all EP's

In Other Words……

- The standard is the GOAL.
- The rationale explains why it’s important to achieve this goal.
- The EP’s identify the steps to achieve this goal.

Comparison of Standards / EPs from 2003 to 2004

Item	Ambulatory Program	Hospital Program
Standards 2003	410	570
Standards 2004	158 (61%) LESS	221 (61%) LESS
MCs in 2003	>1000	>2000
EPs in 2004	664 (34%) LESS	1125 (44%) LESS

Comprehensive Accreditation Manual (CAM) Chapters-Hospital

- **Hospital**
  - Ethics, Right, Responsibilities
  - Provision of Care
  - Medication Mg’ment
  - Improving Org Performance
  - Leadership
  - Management of Environment of Care
  - Management of Human Resources
  - Mg’ment of Info
  - Surveillance, Prevention and IC
  - Medical Staff
  - Nursing

Changes to Hospital CAM (15 chapters, now 11)

- Care of Pt.
- Education of Pt.
- Assessment of Pt.
- Continuum of Care
- Governance
- Management
- * plus Medication Management

- Provision of Care

- Leadership chapter

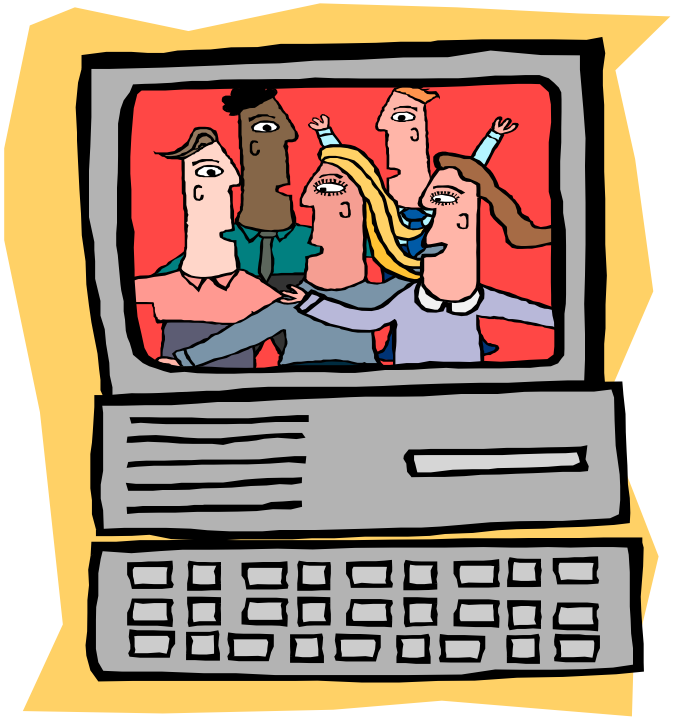
Changes to Ambulatory CAM (11 chapters, now 9)

- Care of Pt.
- Education of Pt.
- Assessment of Pt.
- Continuum of Care

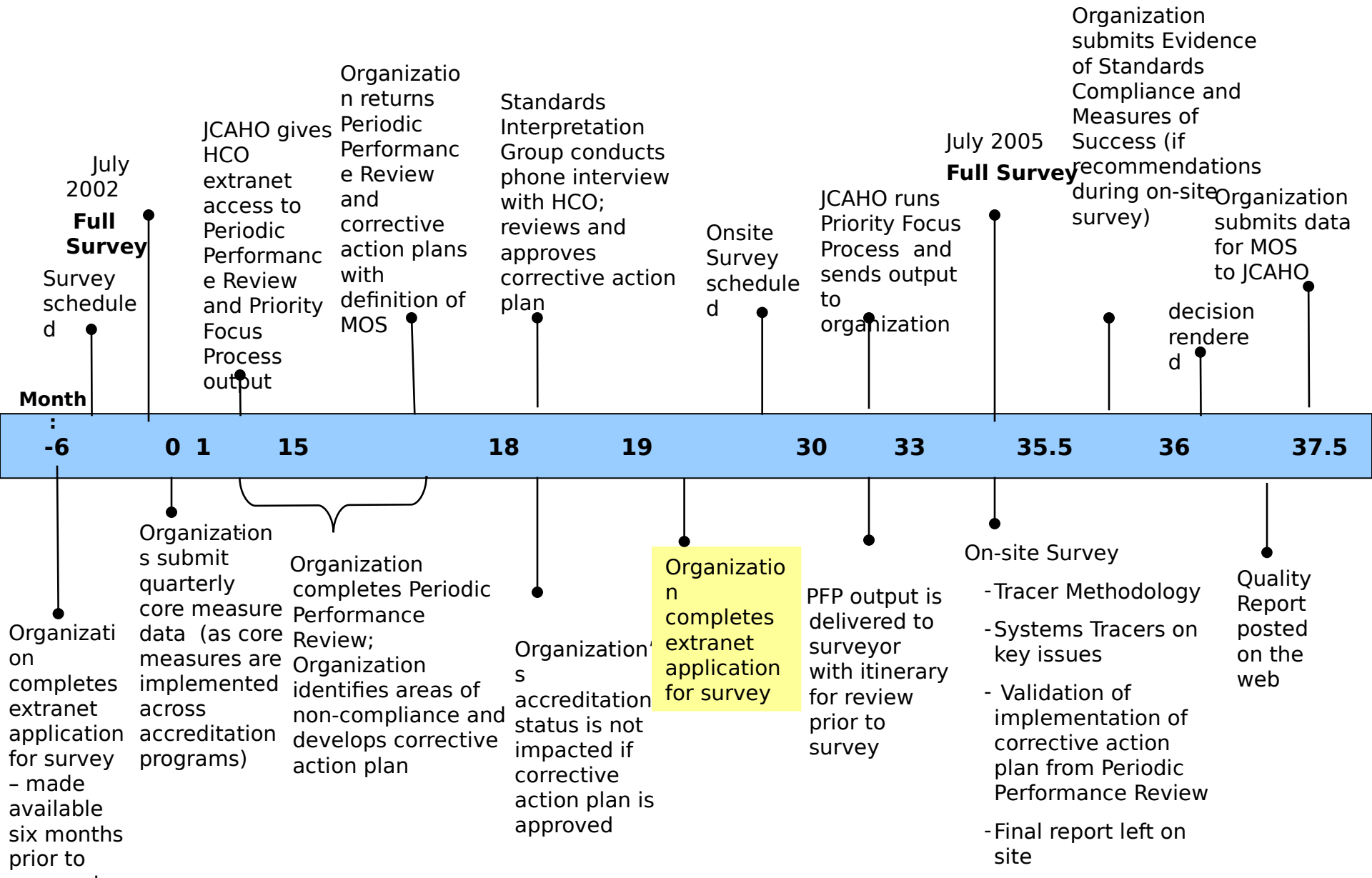
- * plus Medication Management

- Provision of Care

Electronic Application (E-App)



Shared Visions—New Pathways: Triennial Accreditation Cycle
Example of HCO Surveyed in July 2002


July 2002
Full Survey
Survey schedule d
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JCAHO runs Priority Focus Process and sends output to organization
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Full Survey
Organization submits Evidence of Standards Compliance and Measures of Success (if recommendations during on-site survey)
decision rendere d
Organization submits data for MOS to JCAHO
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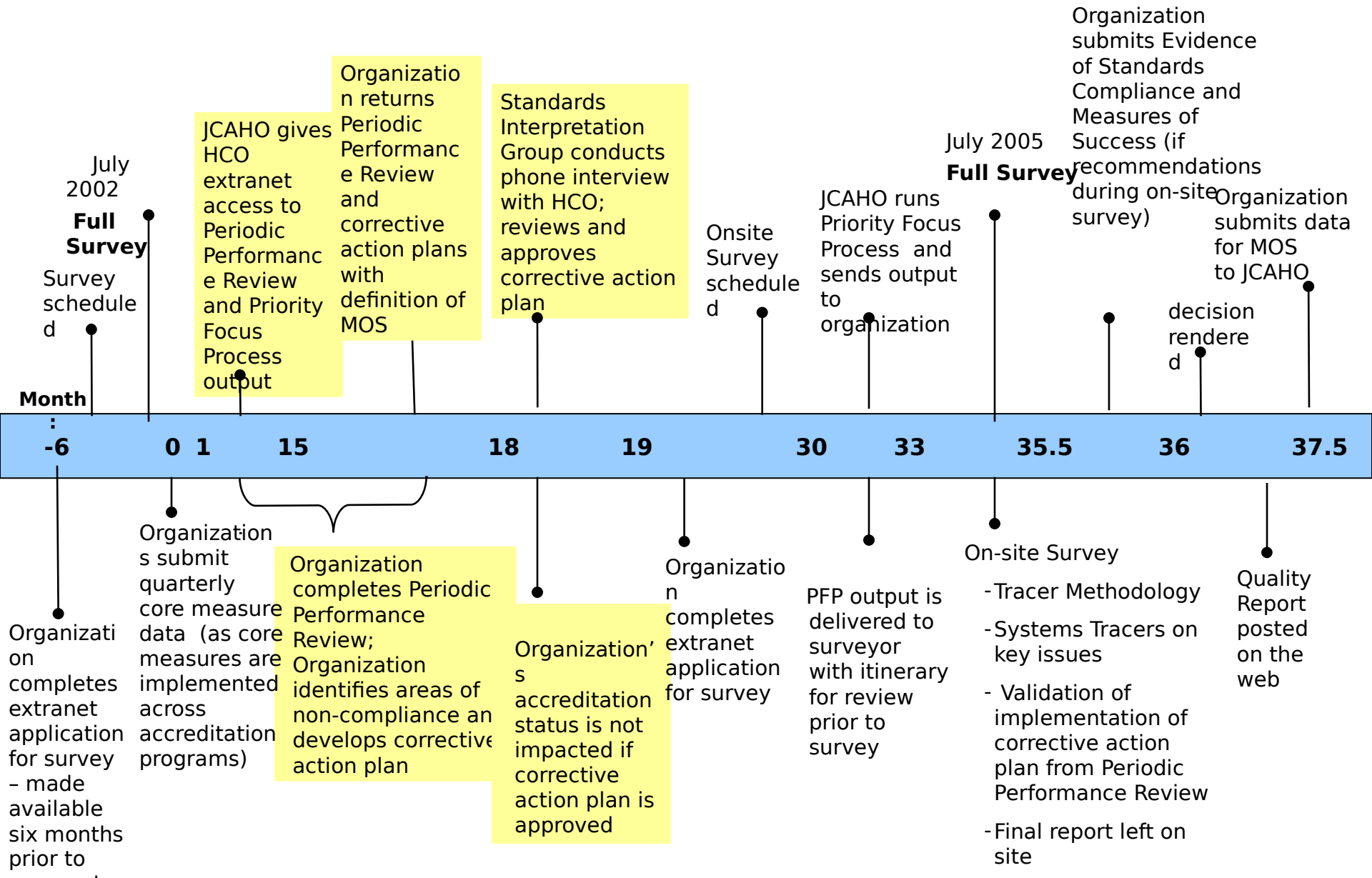
- Final report left on site
Quality Report posted on the web

Benefits of the Improved Application for Accreditation

- Key areas will be pre-populated in the future
- HCO cannot submit unless all required fields are complete
- Account Rep can view on line to assist HCO with timely, accurate submission
- Surveyor can view via laptop technology
- Information contributes to the Priority Focus Process

Periodic Performance Review (PPR)

Shared Visions—New Pathways: Triennial Accreditation Cycle
Example of HCO Surveyed in July 2002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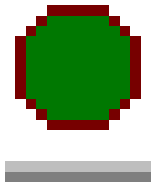
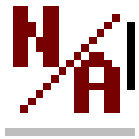
Standards will be shown as:



Compliant

Non Compliant



Not Applicable

The Corrective Action Plan

- For each non-compliant standard the HCO will
  - Describe the planned action for each EP marked as partial or not compliant
  - Develop a measure of success

Measure of Success defined as…

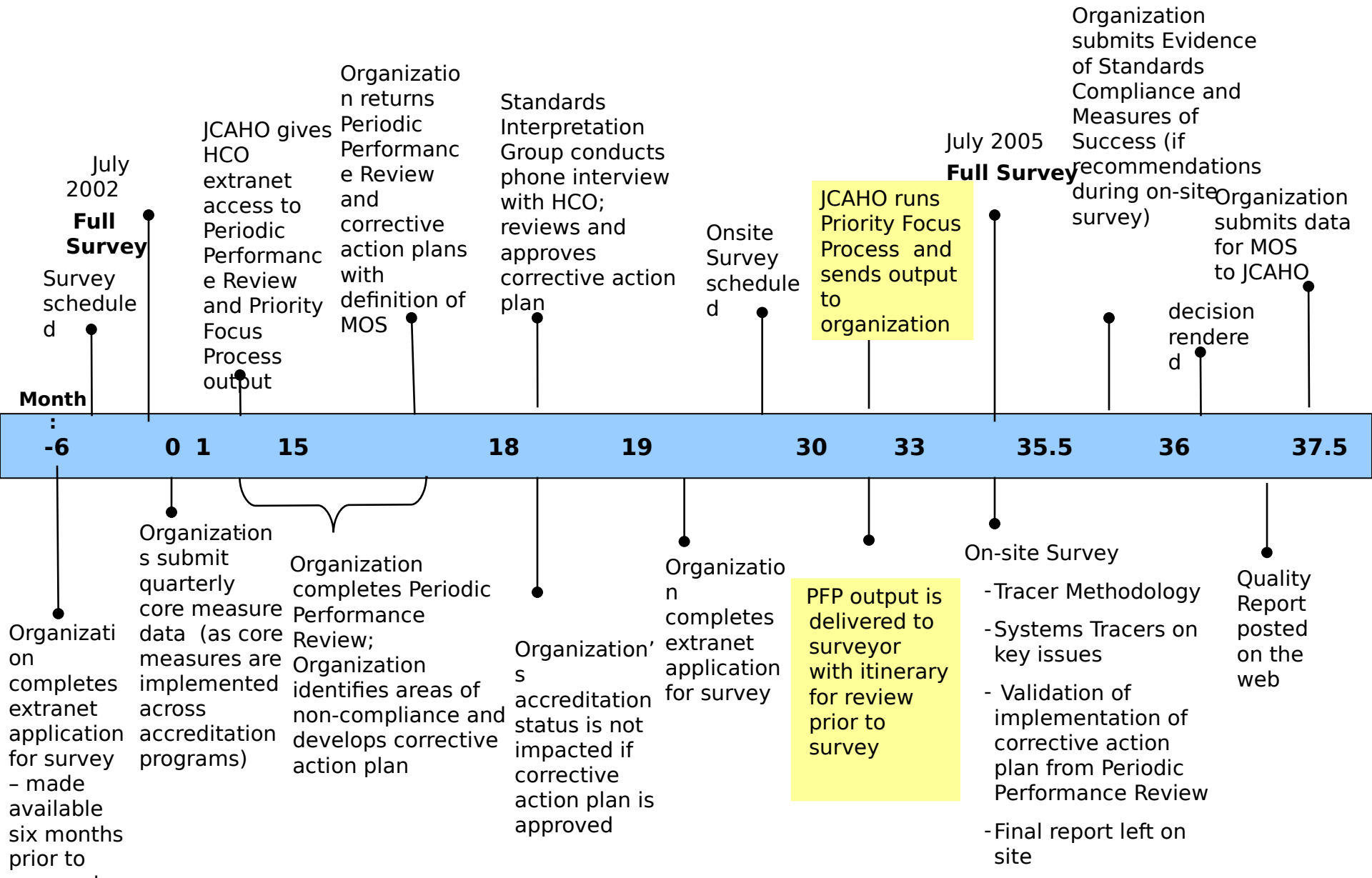
A numerical or other quantitative measure usually related to an audit that validates that an action was effective and sustained

Benefits of Periodic Performance Review

- Org / Surveyor / JC uses same tool
- Enhances intra-cycle interaction with JCAHO
- Supports continuous operational improvement
- Assists HCO’s achieve 100% compliance, 100% of the time

Priority Focus Process (PFP)

Shared Visions—New Pathways: Triennial Accreditation Cycle
Example of HCO Surveyed in July 2002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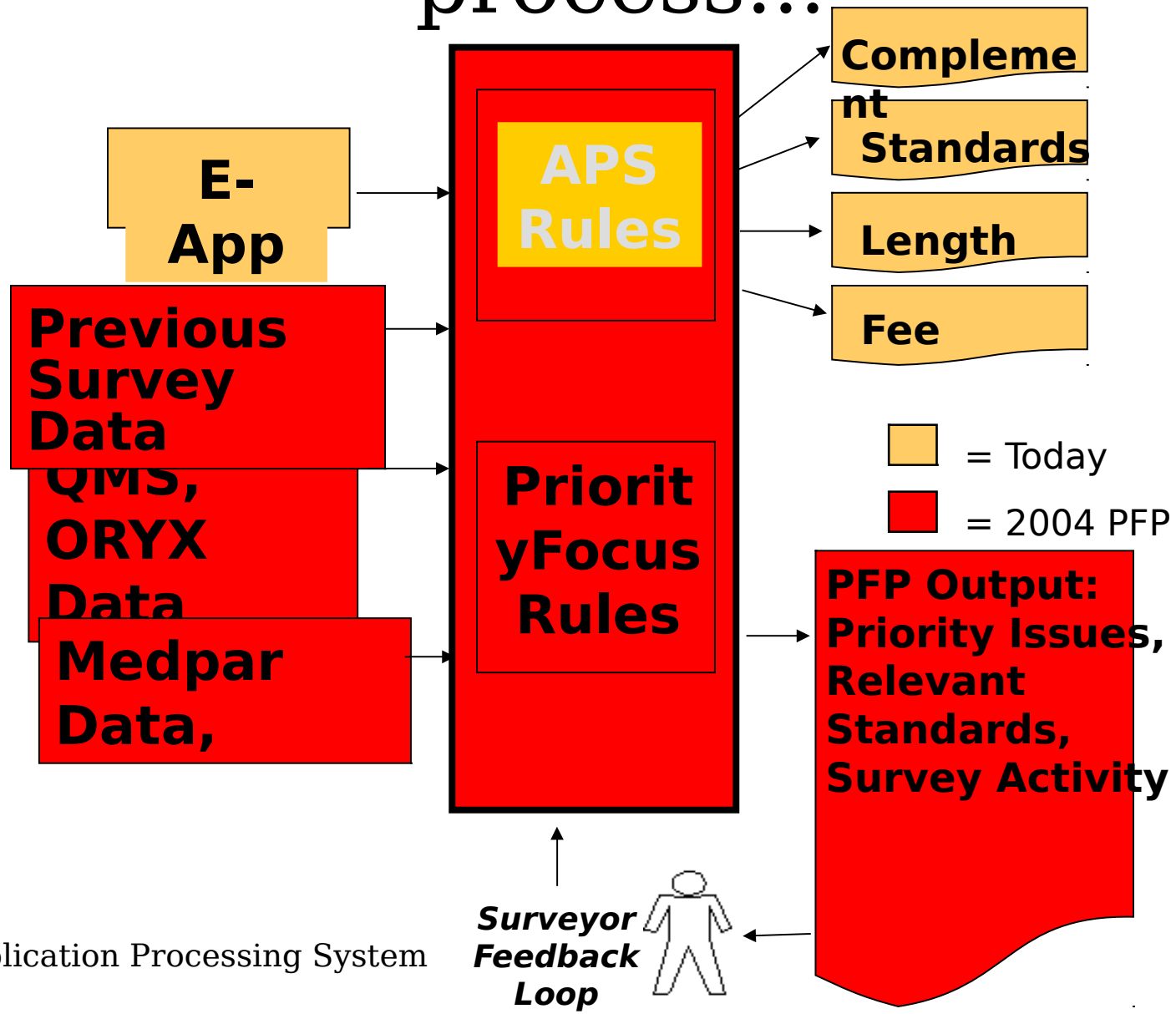
Changing data into information

- PFP is a rules based program that gathers pre-survey data from multiple sources
  - JC data (QMS, ORYX Core Measure)
  - Data supplied by the HCO (E-app,Periodic Performance Review)
  - Publicly available data (MedPar)
- PFP then applies “rules” to identify
  - Potential processes and clinical service groups to address
  - Relevant standards & survey activities

Future rules driven priority focus process…



APS = Application Processing System

Priority Focus Areas include: (Priority Systems)

- Assessment and Care/Service
- Communication
- Competency and Credentialing
- Equipment use
- Infection control
- Information Management
- Medication Management
- Organization Structure
- Orientation and Training
- Rights and Ethics
- Physical Environment
- Quality Improvement Expertise and Activity
- Patient Safety
- Staffing

Priority Focus Process: OUTPUT –

1. Priority Focus Areas (PFAs)
    * Top 4-5

2. Clinical Service Groups (CSGs)
    * Top 4-5

(These significantly impact the onsite survey)

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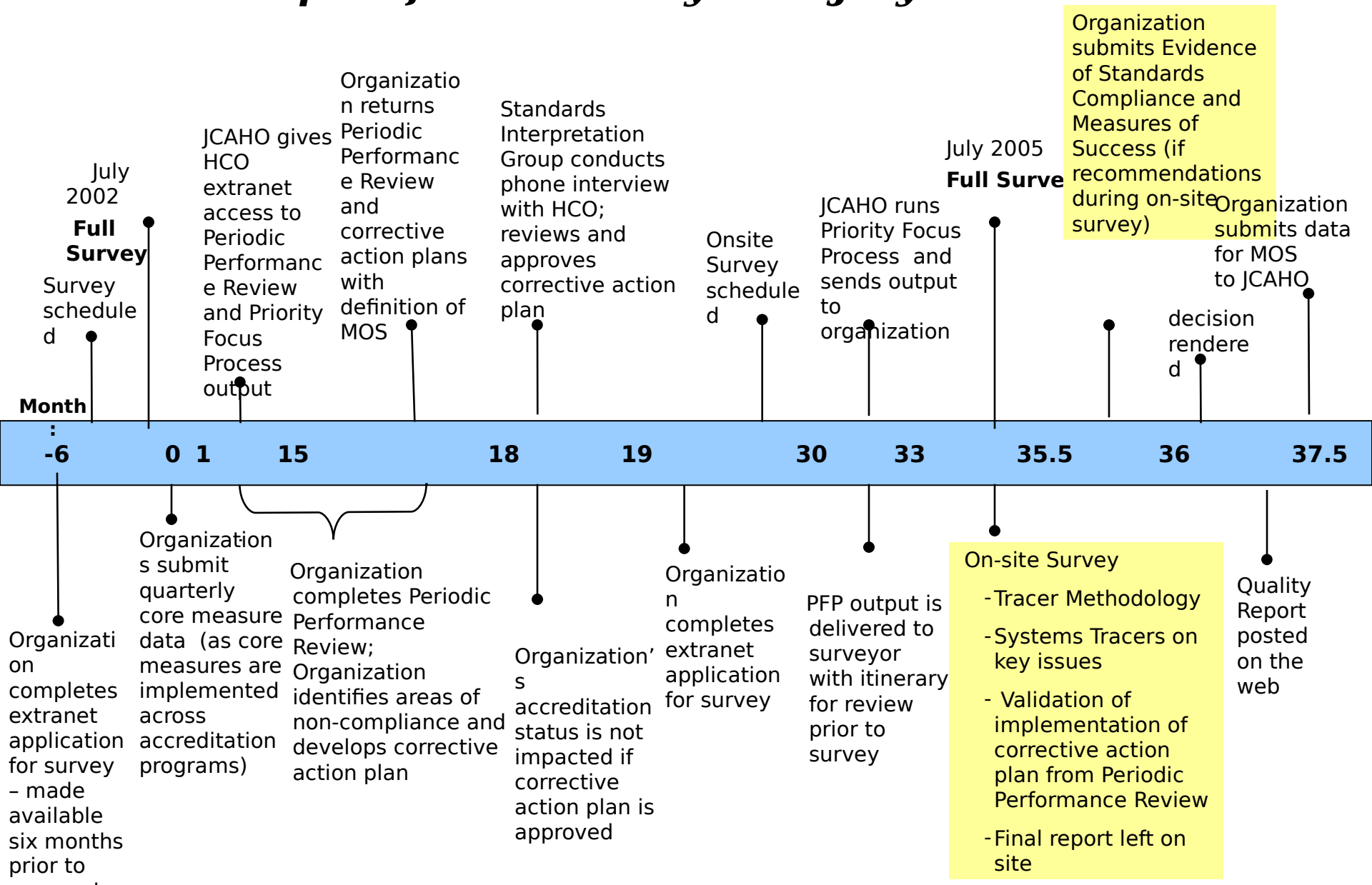
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Current Survey Process	2004 Survey Process
Opening conference	**Opening conference**
Document review session	***No formal document review session***
Leadership interview	**Leadership *conference(s)***
	Validation of the organization's implementation of its corrective action plan created as part of Periodic Performance Review
Prescheduled Visits to patient care settings	***Visits to patient care settings and functional areas, guided by randomly chosen open records (tracer methodology)***
Building tour	***EOC review guided by PFP and integrated for some aspects with tracers***
Environment of care interview	**Environment of care *conference***
Functional interviews	***Systems tracer sessions on topics that are a high priority***

Tracer methodology- a systems approach to evaluation

- The approach, known as the tracer methodology, traces a number of patients through the organization’s entire health care process
- As cases are examined, the surveyor may identify performance issues in one or more steps of the process – or in the interfaces between processes

Contact Information

JC sites

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www.jcaho.org